SELECTION, TRAINING, and UTILIZATION
OF
SUPPORTIVE PERSONNEL
IN
REHABILITATION FACILITIES

Velda Rose Towers
September 26, 27, 28, 1966
Hot Springs, Arkansas

Sponsored by:
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All of us worry about whether there will be enough workers in the health professions during the next decade to meet the growing demands of an expanding population for high quality health and medical services.

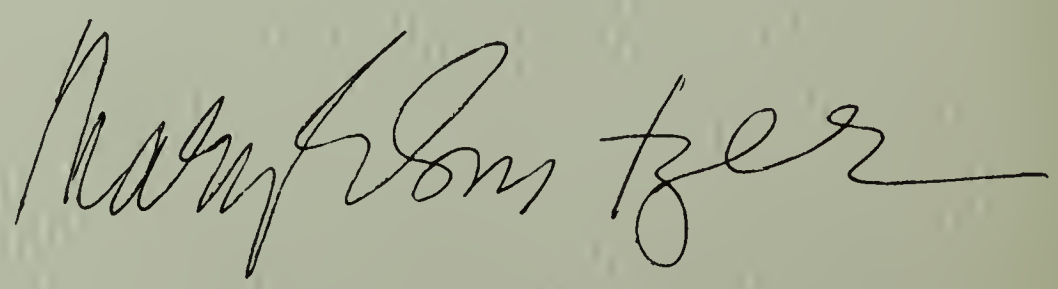
The rehabilitation manpower shortage in these areas is all too well known. Experience has shown that the use of assistants or aides to the professional worker is a positive way of relieving this shortage. It was to this end that representatives of the Association of Rehabilitation Centers and the faculty of the Arkansas Research and Training Center planned an institute on selection, training and utilization of supportive personnel. The VRA has long been interested in training programs for support personnel. We have in the past sponsored other conferences and meetings whose purposes was to study the role and functions of assistants to the professional. We welcome and are very pleased that the Association of Rehabilitation Centers and the Arkansas Research and Training Center are deeply concerned with this important area of manpower shortages.

To initiate and plan an institute on this timely subject was, in itself, an historic undertaking, since for the first time, it brought together the professionals from many health disciplines to present position papers on the ideas of their associations about the use of supportive personnel.

As you read the following pages, you will see, as I did, that there is general agreement about the need as well as the training of these special assistants to meet society's demands. We know that the rehabilitation needs of the public will be met somehow and the centers and facilities have a moral responsibility to assure the provision of quality care. It is also apparent in the proceedings that the professionally-trained personnel appreciate that the service needs of our society are far beyond the present and projected supply. Even if professional workers were available, with existing financial resources, many states and institutions could not support the cost of all the health programs they need.

It is my sincere hope that from this institute the professionals will determine the role of supportive personnel and develop clear guidelines for their selection and training. The task is not an easy one, but a beginning has been made. It is my belief that workers adequately trained to provide assistive and supportive skills to the professional can only enhance the role of the professional in rehabilitation services to the millions of disabled persons. In addition these workers will have a contribution of their own to the rehabilitation services.

The institute has set a milestone for planning and implementation of training programs for supportive personnel. Let us accept the challenge and move ahead to strengthen the health team in numbers, concept and in practice and thereby fulfill one of our responsibilities to the needs of society.



FOREWORD

This is a summary of the proceedings of a conference designed to study the utilization of supportive personnel in rehabilitation facilities throughout the nation. Primary emphasis was given to the official policies of several national professional organizations whose members are involved in providing services within these facilities. Those represented were:

American Nurses' Association, Inc.
American Occupational Therapy Association
American Physical Therapy Association
American Psychological Association
American Speech and Hearing Association
National Association of Social Workers, Inc.
National Rehabilitation Counseling Association.

This report contains a brief background leading to the planning of this conference, a review of the national picture, an overview of the problem as it related to the rehabilitation facilities and copies of position papers as presented to the conference by the official representatives of the professional organizations.

The planning and administration of this conference was a joint effort between the Arkansas Rehabilitation Research and Training Center, Hot Springs Rehabilitation Center, Hot Springs, Arkansas, and the Association of Rehabilitation Centers, Inc., Evanston, Illinois, (headquarters).

This conference was supported in part by VRA Training Grant No. 67-21 to the Arkansas Rehabilitation Research and Training Center from the Vocational Rehabilitation Administration, Department of Health, Education, and Welfare, Washington, D. C.

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Conference Background

During a Spring, 1966, meeting of the Education Committee of the Association of Rehabilitation Centers, Inc., the subject of the role and function of supportive personnel in rehabilitation facilities came into focus as a matter of major importance. It was recognized by this group that the most feasible solution to the personnel shortage in rehabilitation centers probably rested in the proper training and utilization of subprofessional or supportive personnel.

The Committee looked first at the efforts of other groups or agencies to cope with this problem. Unfortunately, the findings of this search indicated that many conferences had, indeed, been held to discuss this topic but few, if any, had resulted in any clear-cut decisions concerning plans of action. In most instances, these conferences concerned themselves with the question, "Should supportive personnel be used?", and not the more important question, "How can supportive personnel best be used for the greatest patient or client benefit?"

During the months immediately following their Spring meeting, the Educational Committee and the staff of the Arkansas Rehabilitation Research and Training Center began planning a conference designed to answer the question, "How can we select, train, and utilize supportive personnel in rehabilitation facilities?" The group recognized, very early, that such a conference must have the involvement of the professional organizations whose members were most often represented on rehabilitation facility staffs. Thus, the decision was reached to ask these professional groups to send an official representative who could deliver a position paper which would reflect the parent organization's views and attitudes on selection, training, and utilization of supportive personnel in its involvement in the provision of services in rehabilitation facilities.

In addition, it was felt that a good representation of the member agencies of the Association of Rehabilitation Centers, Inc. would be needed. The planning group felt that with this configuration of conference participants, the very vital question, "How can we select, train, and utilize these personnel to everyone's best advantage?", could be answered and specific guidelines prepared.

Thus, it was agreed that the Arkansas Rehabilitation Research and Training Center, in cooperation with the Association of Rehabilitation Centers, Inc., apply to the Training Division of the Vocational Rehabilitation Administration, Department of Health, Education, and Welfare, for a short-term training grant in partial support of the conference, "Selection, Training, and Utilization of Supportive Personnel in Rehabilitation Facilities." This application was favorably considered and VRA Training Grant No. 67-21 was awarded to the Arkansas Rehabilitation Research and Training Center.

The planning group contacted 66 rehabilitation facilities to invite their participation in this conference. The professional organizations invited to participate were: American Nurses' Association, Inc.; American Occupational Therapy Association, Inc.; American Psychological Association; American Physical Therapy Association; American Speech and Hearing Association; National Association of Social Workers, Inc.; and National Rehabilitation Counseling

Association. In addition, 11 governmental and private agencies were also invited to send observers. From this group all professional organizations accepted the invitation; 49 rehabilitation facilities sent representatives; and 5 governmental or private agencies sent observers. This kind of representation indicates the magnitude of the interest in this problem from all concerned. In addition, it speaks very favorably of the willingness and interest of the professional groups to give their assistance in attempting to solve the personnel problem.

EDUCATION AND TRAINING FOR TECHNICIANS IN THE HEALTH FIELD

by

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Division of Public Affairs and Education
W. K. Kellogg Foundation

I have assumed that my mission here is to share with you what I have identified as significant developments in education and training for technical level personnel in the health field. Your deliberations here will necessarily be influenced by educational programs already under way and trends in the development of new programs by a number of different educational and training agencies.

In the short time available I can only remind you of a number of considerations that are directly related to your concern in regard to selection, training, and utilization of supportive personnel in rehabilitation facilities. I shall leave it to subsequent discussants to analyze the specific applications to their particular field of specialization.

The trends that I have been able to identify in the training of health service workers are a direct response to changes in social and educational patterns and health services practices. Some of the forces that are influencing the educational trends are:

1. The knowledge explosion
2. Increasing use of medical services and expanding health services
3. Changing roles of ancillary personnel in the health field
4. Development of a multimedia approach to instruction
5. New concepts in the use of auxiliary personnel by professionals.

These forces have, in turn, resulted in several educational trends:

1. A process analysis approach to curriculum planning
2. Recognition of levels of health workers
3. Identification of the unique and appropriate contribution of a variety of institutions to education and training for health workers
4. Innovations in providing clinical experiences for college students
5. New efforts at interorganization and regional planning for education and training

6. Greater use of the "Core Curriculum" concept

7. Applications of multimedia to education for health workers

8. Increased emphasis on counselor training for the health field

9. Greater educational mobility for students between institutions and programs

10. New programs for teacher preparation.

It is particularly important that these trends be identified early and guided in a constructive way to avoid an unfortunate duplication of efforts and a confused overlapping of official and semiofficial "standards" as well as jurisdictional claims and counterclaims.

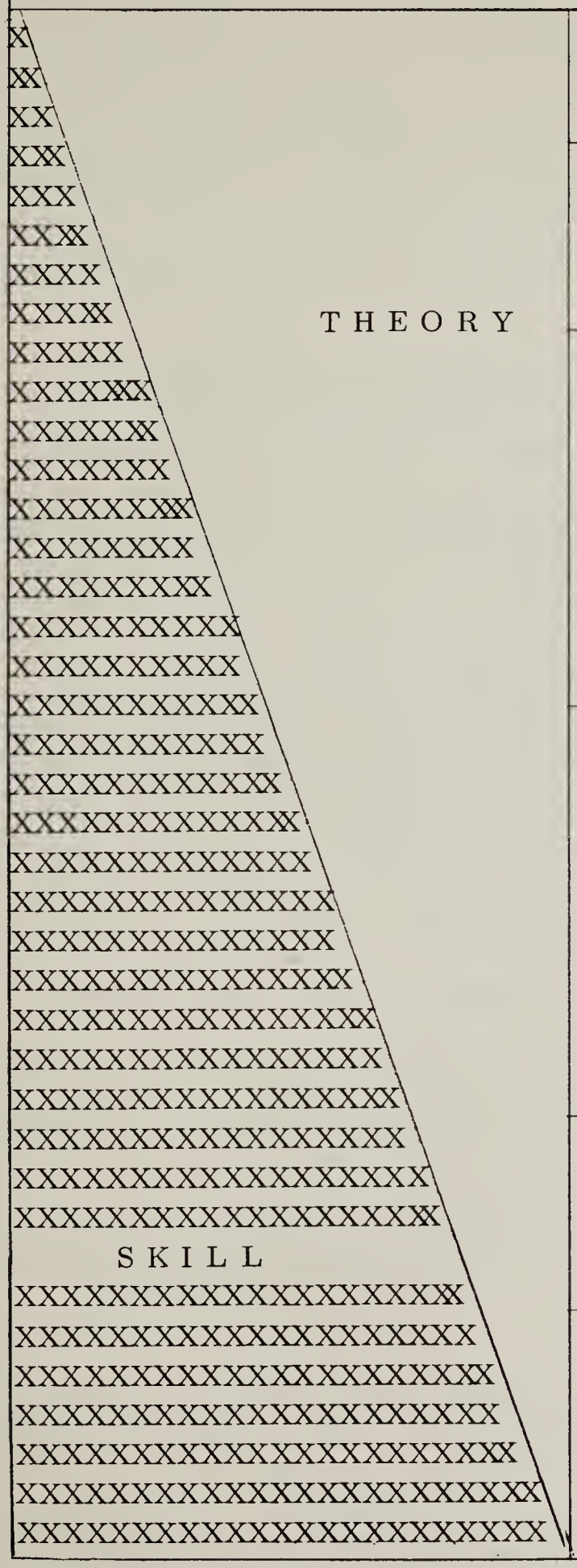
First, we must recognize that the traditional health team of doctor, dentist, and nurse can no longer service, without assistance, the health needs of patients. There is no need to labor the point; the evidence is on all sides. However, to bring the picture dramatically up-to-date in terms of the magnitude of change in the composition of the modern health team, let me quote from the recent Coggeshall Report, Planning for Medical Progress Through Education.

"Once it took only one doctor to resign himself and the child's parents to the inevitable death of a "blue baby." It now takes a team of medical specialists and auxiliary personnel to correct the congenital abnormality of a baby's heart to insure the child a normal life span. At least 15 persons, including four surgeons, are needed in the operating room for the repair of a congenital lesion of the heart. More than 100 medical specialists, nurses, and skilled technicians are involved in preparations for, and performance of, the operation and in the postsurgical care of the patient."

Simply stated, the knowledge explosion has overwhelmed the health field, as it has so many other areas of human endeavor. It takes many more skilled hands to apply modern medical knowledge. The physician increasingly must analyze, plan, and administer services which are provided by others; others to whom he delegates in large measure routines carried out under his direction.

Some of the most enlightened planners are undertaking a careful analysis of the skills and knowledge currently being demanded of a worker to function safely and effectively in each allied health profession. Constant review will be necessary because functions are wed to the art and science of medicine and these are continually changing. Not only must individual curriculums change as medical practice changes, but planners must be alert to demands for new categories of personnel. To help educators relate specific levels of preparation and service to the broad spectrum of health service personnel (professionals, technicians, and practical aides), the following chart has been prepared.

THEORY - SKILL SPECTRUM IN THE HEALTH FIELD



RESEARCH SCIENTIST

PHYSICIAN AND DENTIST PRACTITIONERS

PARAMEDICAL-PARADENTAL:

R.N. (B.S.)
Dietician
Pharmacist
Medical Record Librarian
Occupational Therapist
Physiotherapist

TECHNICAL ASSISTANT:

X-Ray Technician
R.N. (A.D.N.)
Medical Record Technician
Dispensing Optician
Occupational Therapy Assistant
Inhalation Therapy Technician

PRACTICAL ASSISTANT:

Licensed Practical Nurse
Psychiatric Aide

AIDE:

Orderly-Nurse Aide
Dietary Aide
Housekeeping Aide

Can the hospital continue to carry the major responsibility for financing, administering, housing, staffing, and planning for such a broad and complex training responsibility? At one end of the occupational scale the answer is probably "yes". On-the-job education for aides, orderlies and others who are almost exclusively concerned with "how" and very little with "why", may continue to be the major responsibility of the hospital. The education of other diverse groups on the subprofessional level requiring formal education calls for large, professionally competent faculties, increasingly complex laboratory facilities, and massive financial support. In these instances, the education will probably move more and more into educational institutions; into the high schools on the assistant level and into two-year colleges on the technical level. The hospital will become an extension of the college campus: the clinical laboratory.

TRAINING PROFESSIONALS TO UTILIZE TECHNICIANS

A trend toward recognition of the responsibility of professional practitioners to utilize more effectively the skills and knowledge of technical personnel has been spearheaded by the dental profession. With financial help from the federal government, dental schools have instituted programs specifically designed to teach graduates how they can serve public health needs better through a careful sharing of appropriate functions with dental auxiliary personnel.

The Surgeon General recently highlighted this important aspect of health service. At the 1965 White House Conference on Health he stated, "Year by Year, our top professional personnel are being trained to perform still more complex tasks. How long can each profession afford to hang onto its simpler functions - the routine filling of a tooth, for example, or the several easily automated steps in a medical examination? How can we train the physician or dentist to make full use of the skills available in other people, freeing himself to perform only those duties for which he is uniquely qualified?"

INNOVATIONS IN PROVIDING CLINICAL EXPERIENCES FOR STUDENTS

The impetus for the recent trend to transfer training responsibilities from clinical agencies to educational institutions stems from economic considerations, the tendency of high school graduates to prefer the college setting for post-secondary education, and problems encountered by hospitals in recruiting and retaining qualified faculty. However, the specific innovation that has made the shift in educational responsibility possible is a relatively new technique for utilizing clinical agencies as extended college campuses or clinical laboratories.

An earlier relationship between colleges and hospitals called for paramedical students to begin with courses in general education and to develop their background in the physical and biological sciences on the college campus. The student, subsequently, moved to the clinical agency where he came under the tutelage of agency personnel. Here he was exposed to the occupational setting, gained specific occupational know-how, and practiced clinical skills on the job. The inevitable conflict between education and service frequently plagued the instructor-practitioners and hampered the process of student assignments for clinical practice. A more recent approach calls for occupational instructors (nurses, laboratory technologists, or whatever their field) to function as full-time members of the college faculty.

These instructors integrate their teaching with the college humanities and science courses and accompany their students to the clinical agency to select appropriate clinical experiences for students. The college instructor takes full responsibility for supervising the student's learning experiences during the time that the student works with patients in the clinical agency. This arrangement requires a carefully developed and continually evaluated plan based on a written contract between the clinical agency and the college. The contracts vary with the institutions and the circumstances, but they usually are built around one key responsibility of the clinical agency and another central responsibility of the college; namely:

A. The clinical agency agrees to provide opportunities for clinical practice and for observation on the wards and in the various departments of the agency.

B. The college agrees that its instructors will go through proper agency channels to make plans for observations and for clinical experience and that college instructors will provide all supervision and instruction required in the program.

MOVEMENTS TOWARD INTERORGANIZATIONAL AND REGIONAL PLANNING

Another trend, one of the most promising, is an increasing movement toward interagency and multidiscipline planning for education and training in the health field. There are a number of encouraging examples. I will not attempt to cite all of them or even suggest which are the most important. The President's recently appointed Health Manpower Commission comes to mind immediately, as does the National Advisory Health Council Subcommittee on Allied Health Professions. A new Manpower Resources Program has just been inaugurated by the U. S. Public Health Service. A division of the U. S. Office of Education already has a standing Advisory Committee on Health Occupations Training. The work of the National Commission on Community Health Services generated 70 recommendations regarding health manpower. Also extremely promising are two newly formed interorganization committees on health technology education: one between the American Association of Junior Colleges (AAJC) and the National Health Council and another between the AAJC and the National Council on Medical Technology Education. The AAJC and the National League for Nursing have had a similar interorganization committee for many years. Writing on "The Increasing Role of Paramedical Personnel" in the September 1965 issue of The Journal of Medical Education, Dr. Robin Buerki states, "It would seem that junior colleges across the country offer the most appropriate and the most immediate solution to the problem of training in specialty areas where shortages exist. Technical education in many paramedical specialties could easily be accomplished in a two-year curriculum which would also provide an opportunity for .... liberal arts subjects." In the light of this statement it is important to note that the first task the AAJC-NHC Committee has set for itself is that of writing guidelines for the development of sound educational programs for health technicians at the junior college level.

In a few areas, regional study and planning groups comprised of employers, practitioners, and educators are providing a framework for mutual planning regarding education for the allied health professions. As I suggested at a recent conference, "without such an Allied Health Professions Regional Education and Training Council, or some similar organization, health needs of our citizens will continue to be poorly served by the existing laissez-faire

attitude which forces each health agency and educational institution to make a unilateral assessment of educational priorities and educational practices. Hospitals will continue to establish training programs in desperation when forced by crises created by personnel shortages. Colleges will establish or expand programs only when government or philanthropic funds are offered for a particular program or when a usually persuasive professional association gains the ear of a college administrator or college board member."

THE "CORE CURRICULUM" CONCEPT

The development of a "core curriculum" at community colleges offering several occupational programs for health service technicians is a promising trend. Curriculum study groups have identified general areas of knowledge, skill, and understanding common to all health technologies. These commonalities constitute the basis for a beginning curriculum pattern for all students electing the health field. College instructors and facilities can be utilized with increased efficiency if such a health technology foundation program is offered to all entering students who think they are interested in the health service field. In addition to building a common scientific base for the technology they will study during subsequent semesters, students are introduced to a broad spectrum of career opportunities and assisted in selecting a specific career for which they have demonstrated interest, ability, personality, and character. "Core curriculum" students:

1. become oriented to and gain understandings of health service resources.
2. gain understanding of an experience with team relationships.
3. become acquainted with health field ethics.
4. gain beginning knowledge and understanding of pathophysiology and pathopsychology.
5. gain an understanding of how diseases are treated.
6. develop beginning skills in maintaining environments conducive to patient welfare.
7. gain skills to achieve and maintain asepsis.

Recruitment is also simplified if students can be attracted to programs leading to careers in the health field generally, rather than requiring them to make a premature choice of a technical specialty based on a less than complete knowledge of the fields from which they may choose.

THE USE OF MULTIMEDIA

Promising ways to stretch instructional talent have burst upon the educational scene in great profusion during the past decade. Programmed instruction has been utilized in a number of ways for the education of health workers. At one extreme, programs have been developed for physicians on the diagnosis of myocardial infarction. At the other end of the scale, an elementary program for aides and orderlies teaches medical terminology by making extensive use of mnemonics.

Television has been employed imaginatively to provide for transportation, magnification, memory, transformation, associations, and image multiplication. New experiments in connection with clinical teaching promise dramatic instructional breakthroughs. Groups of hospitals, anxious to share master teachers in the process of upgrading supervisory skills of their personnel, are paving the way to more efficient use of the best teachers by using television for inservice education.

The most recent efforts to merge education and technology have called for applications of computer science to the problems of education for the health field.

An experience may be simulated and, through dialogue with the computer, the student can either be taught how to deal with the situation or be tested on his ability to cope with it. An example from an actual dialogue from a medical program will illustrate the point:

A hypothetical situation has been presented to the student and he must ask for various kinds of information in order to make his diagnosis. Note that he may ask for the information in the order that he deems correct. The following exchange occurs after a series of preliminary requests and responses: (The capitalized words are those of the student, the others are the computer's.)

COUGH?

Yes, developed yesterday.

BACKACHE?

No.

HEART EXAM?

Not enlarged to percussion but low-grade systolic murmur at apex. Otherwise normal.

ABDOMINAL EXAM?

Diffusely tender, splintering noticed in lower right quadrant and occasionally radiating to right flank area.

THE GRIPPE?

There's insufficient information for any conclusive diagnosis at this time. You're not being careful!

MUSCULOSKELETAL SYSTEM?

Essentially negative, except for generalized weakness and aching.

EXTREMITIES?

Normal, except nail beds are questionably cyanotic but difficult to determine because of patient's skin color.

RECTAL EXAM?

You're not being careful! The patient is too acutely ill for rectal examinations.

LABORATORY REPORTS?

Fine. Which lab tests would you like to have done?

RBC.

A red count will be done. Results will be sent to you as soon as possible.

Far out? Perhaps, but computers represent an important instructional trend. Computer terminals can be placed at convenient locations at any distance from the computer itself and be used at each location virtually at the convenience of the user.

COUNSELOR TRAINING FOR THE HEALTH FIELD

Brief note should be made of the need for continuing education for high school counselors and others who are influential in steering potential students into the most appropriate educational programs for health careers. The Health Manpower Source Book divides the spectrum of health occupations into approximately 40 categories, and the newly released Health Careers Guide Book subdivides these into more than 200 separate health occupations, including specialties and subspecialties. Even to keep moderately well-informed regarding these fields and the educational opportunities leading to these careers is a monumental task. There is a trend, only in its infancy, to provide regular inservice education for counselors regarding health careers. A specific example of this trend was the recent two-week summer institute of the Health Careers Committee of the United Hospital Fund of New York. Counselors from the greater New York area were offered an opportunity to bring their knowledge up-to-date by working with leading educators and employers of workers in the health field.

THE COLLEGE PROFICIENCY EXAMINATION PROGRAM

Several educational groups are hard at work on plans for a program which will permit students, by means of examinations, to acquire college credit without regular college attendance. This new approach may help overcome deterents to ambitious individuals who wish to advance themselves on the vocational ladder. In the past, colleges have found it difficult to grant advanced standing to health-related workers who have received their initial training in other than collegiate institutions. A solution to this serious transfer problem may be in the offing.

The essence of collegiate education is the learning that takes place. It ought not to matter when or how the competence, knowledge or skill is obtained if it is comparable to the achievement ordinarily developed by individuals who complete college courses in the field.

To help colleges determine credit allocations for off-campus or out-of-course learning, a College Proficiency Examination Program has been established by the New York State Board of Regents. The College Entrance Examination Board has recently created a Council on College-Level Examinations to develop a similar program on the national level. The examining groups will not give credit -- this is solely a matter for the colleges -- but they will certify that, within the limitations of the examination, a level of performance above the minimum required for earning credit in courses has been demonstrated.

The complexities involved in these new college proficiency programs should not be minimized, but they offer at least a ray of hope to those now caught in the web of academic bookkeeping.

An even more important trend for promoting student mobility and institutional articulation is the development of programs in pretechnical education. The comprehensive high school, Cooperative Education Centers, and similar institutions are developing a unique role in the field of education and training for health service workers. In addition to establishing programs leading directly to employment at the aide and practical assistant level, they are becoming more and more interested in pre-technical education leading to college technical programs. Under this program, students enroll during their eleventh and twelfth year in a course of study which assures that they will have adequate prerequisite courses in physical and biological sciences and general education courses required for community junior college entrance to a health service technology program. During the last two years of high school, they learn beginning technical skills in the health field. The students are exposed to a wide range of health technologies through field visits to health agencies. In some instances, they are afforded opportunities to perform tasks at an aide level in these agencies. The pretechnical program, coupled with intensive student counseling,should provide a much needed feeder mechanism for health service technology programs.

A DISTINCTION BETWEEN PATIENT AND NONPATIENT CONTACT OCCUPATIONS

The Bureau of the Census identified 2.6 million individuals employed in the "Health Services Industry" in 1960. This was a 54 percent increase in the decade between 1950 and 1960. Recent trends indicate even more dramatic expansion in the near future. However, it is clear that various categories of health workers are subject to differential growth rates. From the standpoint of education and training, it seems important to draw a distinction between two broad classifications of workers in the health service field: a) occupations that require the worker to provide a direct service to an individual, i.e. <u>patient contact</u>, and b) occupations that support the operation of health agencies and individual practitioners, i.e. <u>institution and staff support</u>. The emotional stability, maturity, and native sensitivity of candidates for <u>patient contact</u> jobs is of a different variety than that demanded of those engaged in housekeeping, business, laboratory, and supply functions for <u>institution and staff support</u>. Both categories are vital to the growth of the nation's health service capability. However, the distinction is important when planning for job development and training in the health field. The ill and otherwise handicapped are least able to defend themselves from inept service. Adequate education for those who will be entrusted with the health of their fellowmen, on whatever level, is one of the most vital concerns that currently face educators in a variety of institutions.

Ambitious plans for a broad expansion of educational programs for health service workers have dealt with curriculum organization, financing, student recruitment, laboratory facilities, arrangements for clinical practice, and textbooks. Very little is being planned to build a trained corps of instructors. A few universities have undertaken programs, particularly in nursing, to enable an individual to shift his vocation from paramedical practitioner to accomplished teacher in the health service field. Objectives for these teacher training programs are based on the assumption that the trainee is a competent experienced paramedical practitioner. The composite goals of these programs are to enable the teacher trainee:

1. to become familiar with the underlying philosophy and operating procedures of the educational institution in which he will teach.

2. to learn to use a variety of instructional techniques, i.e., lecture-discussion, demonstration, independent study assignments, audiovisual media, directed clinical practice, etc.

3. to organize a curriculum in his field using all tools of instruction such as tests and measurements, library resources, a variety of health agencies for practice and observation, etc.

4. to bring his knowledge up-to-date in his technical field and add to his depth of understanding in this field.

5. to supplement, as appropriate, his general background in the physical and biological sciences and the humanities.

I end my discussion of trends under the rubric of teacher training, because it is central to all. Programs for identifying outstanding health service workers and preparing them as instructors must have top priority in any plan for job development and training. Without such a corps of teachers, energy expended on curriculum development, facilities planning, student recruitment and planning for financial support is misdirected. When the teachers are available the other facets of the problem tend to fall much more easily into place as we work toward the ultimate goal: a trained manpower pool to serve the health needs of all our citizens.

Finally, I urge you to study carefully the Allied Health Professions Personnel Training Act of 1966 with reference to its implications for the preparation of supportive personnel in rehabilitation facilities. May I quote from the Committee Hearings on this bill in the House of Representatives? "The Committee did not think it wise to define categorically those curriculums which could be classified as allied health professions eligible for assistance under this legislation. Rather, it was considered advisable to allow the Surgeon General to specify by regulations which occupational groups shall be included. This flexibility is necessary since advances in medicine and science require not only increased numbers of health manpower, but also new skills and indeed new occupations." The legislation provides that determinations as to eligible curriculums are to be made by the Surgeon General.

There is your open invitation and your challenge. This conference can respond to the challenge. What skills and knowledge do supportive personnel in rehabilitation facilities need? Which educational institutions eligible under this act can develop programs to supply trained personnel? How can you work with these education agencies to help assure that you will have the right quality and quantity of personnel as rapidly as possible?

REHABILITATION FACILITIES' NEEDS FOR SUPPORTIVE PERSONNEL

Paper Prepared for Presentation at

INSTITUTE ON SELECTION, TRAINING AND UTILIZATION OF SUPPORTIVE PERSONNEL IN REHABILITATION FACILITIES

By: Charles E. Caniff
Kenneth B. Peiser

Hot Springs, Arkansas
September 26-28, 1966

REHABILITATION FACILITIES' NEEDS FOR SUPPORTIVE PERSONNEL

Twenty years ago, when rehabilitation facilities began springing up in our country, major topics of discussion when center directors gathered were usually those of educating the professional and service agency community to the value of rehabilitation services, the promotion of referrals, and raising funds to cover costs of operation.

While these problems are still with us, rehabilitation is an increasingly accepted, utilized, and financed component of our programs for the chronically handicapped and "disadvantaged".

While the shape, dimensions and directions of the rehabilitation movement are not yet stabilized or even well-defined, it is an indisputable fact that more facilities and programs are being established in increasingly diverse institutional and organizational settings for almost every kind of human problem, ranging from the catastrophically physically disabled, the mentally and emotionally handicapped, to the socio-culturally deprived.

As the techniques of physical restoration, retraining and multidisciplinary programs have proven their value and effectiveness, rehabilitation services and programs have been organized and applied to this expanding array of human problems, with increasingly successful results. The dramatic rehabilitation success story of ten years ago is a relatively routine accomplishment today, while those individuals whose problems seemed so complex or insoluble because of their limited physical, mental, emotional or cultural capabilities are being increasingly served in rehabilitation centers today.

A dramatic example of this expansion of the application of rehabilitation is the current national contract of the Association of Rehabilitation Centers with the Office of Manpower Policy Evaluation and Research of the United States Department of Labor, through which five demonstration projects in rehabilitation centers have been developed to serve selected samples of the "hard core unemployed" - the individuals who all too often "fall through the cracks" of our health and social welfare programs, being considered incurable and/or unemployable. These are the people who do not appear in our national statistics on the unemployed because they are not by usual standards considered employable.

In these projects, rehabilitation centers are conducting case-finding, screening, evaluation, training and vocational placement services for such groups as:

- the severely disabled Negro and Mexican-American population in the Los Angeles area

- long-term welfare recipients with a combination of educational, socio - cultural and sometimes physical deficits in Dallas

- the "unemployable" because of multiple social, physical and educational problems in Hawaii

- the "rural poor" in southern Indiana

- culturally deprived individuals from the Mexican-American, Indian and Negro population in Arizona

With this expansion of application of the rehabilitation concept to every type of chronic deficit experienced by human beings, the one trend that we can identify with complete assurance is that rehabilitation facilities and programs will continue to expand, will serve more people with increasingly complex problems, and will require vastly increased numbers of workers at all levels of education and training. This is a crucial issue, complicated by current shortages, and questionable practices in effective use of currently available manpower.

The problems of health manpower - today and in the years ahead - has been graphically and dramatically stated with increasing urgency during the past few years. Most recently, the United States Department of Labor and Health Education and Welfare sponsored a national conference on Job Development and Training for Workers in Health Services. The proceedings of this Conference_/[1] should be required reading for every rehabilitation center director. At this Conference, Francis Keppel, then Assistant Secretary for Education, U.S. Department of Health Education and Welfare, stated that we will soon have to produce 10,000 new jobs every month to meet our health manpower needs._/[2] Mr. Wilbur Cohen reported at the same conference that hospital costs are increasing at the rate of 6-7% per year. He further stated that we spent $40 billion for health services in 1965, about 5.9% of our gross national product, and this will increase to almost $50 billion by the end of this decade._/[3]

The manpower problem for rehabilitation facilities is further complicated, since their staffs include not only a wide sampling of workers found in general hospitals, but also workers in the fields of psychology, social work, counselling and guidance, vocational training, special education and - in the case of workshops - workers with industrial skills.

Indeed, the comprehensively programmed and staffed rehabilitation center epitomizes in microcosm the total problem of trained, competent effective health manpower that faces our nation today.

The current shortages and future needs of the major professions represented in rehabilitation center service programs have been projected, and I am sure will be described in considerable detail by their representatives who will speak later at this Institute. At this point, it should suffice to say that our current shortages are so great and projected needs so astronomical, that we are forced to identify, test and demonstrate new ways in which we can effectively apply the growing knowledge, skill and techniques to help the millions who can benefit from them.

In essence, then, our problem can be realistically stated, "How can we best utilize our scarce (and increasingly costly) professional and technical manpower so that the greatest number of individuals can be served in programs of high quality?".

Of course one answer is to recruit and train more young people in these professions. We must continue and accelerate our efforts in this area.

A second approach, which is the subject and purpose of this institute, is to develop means through which the knowledge and skills of the professional are extended and applied to more people through the use of trained assistants and supportive personnel.

The first formal approach to this problem by the Association of Rehabilitation Centers was undertaken when, in July 1965, it executed a contract with the Bureau of Apprenticeship and Training, U. S. Department of Labor, to develop and finance on-job training programs for supportive personnel in rehabilitation centers. Under this contract, ARC agreed to develop subcontracts with rehabilitation centers to train and employ 500 such personnel, recruited and selected mainly from among the unemployed, over an 18-month period.

At this date, ARC has developed subcontracts with 20 centers, for 775 trainees, which provide for reimbursement for training costs of about $220,000--or $284 per trainee.

This represents a better than 50% excess of trainees over our original quota, and based on interest generated and experience gained, we are now negotiating a second contract for training an additional 750 supportive personnel during the next 18 months.

The 775 trainees represent 50 different occupational titles, of which 29 are for jobs which assist the professional in providing direct patient/client services. The average length of training is 13.44 weeks, with a range from 4 to 26 weeks.

Average minimum wage rates for all trainees is $1.41 per hour, and the average maximum is $1.72, with a range from $1.15 per hour to $2.50.

Of the 50 occupations, 34 (over two-thirds) are described as offering opportunity for further promotion. Nineteen occupations are in the medical service area, 5 in psychosocial services, 5 in vocational/educational, and 21 in office, clerical and general service personnel.

In an effort to further delineate the current use and estimates of need for ancillary workers, the ARC research staff developed and distributed a questionnaire on supportive personnel to over 200 rehabilitation facilities. Thirty-two centers, representing 172 service departments, returned questionnaires in time to be studied and analyzed for reporting at this Institute. We expect that reports on a much larger sample will be presented at our Annual Workshop in December.

The questionnaire was directed to the heads of patient-client service departments in centers, asking them to report on utilization, effectiveness and additional needs for supportive personnel in their programs.

Probably the most important fact we have learned from the data gathered is that we are already using a high volume of supportive personnel. For all departments there is an average of one professional staff member to every supportive worker. (Supportive staffs are defined as individuals directly assisting the professional in his clinical services to patients/clients, excluding general clerical help, etc.)

There is a wide variation, however, in utilization by various departments, from three supportive staff to every one professional in nursing to less than one to every ten professionals in speech and hearing departments. The average ratio for all departments other than nursing is two supportive staff for every five professionals.

This wide variation between the use of supportive staff in nursing departments and other service areas needs further exploration. There are probably a variety of reasons, primary of which is the absolute necessity of providing care for a patient in bed, while in social casework, for instance, the urgency for full coverage is not a "life or death" matter. The nursing profession, whether by choice or necessity, has quite obviously done most in developing ways of using ancillary personnel. While some of the related professions may decry this development, patient coverage is being provided, and to the extent that these other services become "essential" rather than "desirable," ways will be found to use more supportive staff.

In spite of the wide and increasing usage of supportive personnel, there are still major shortages. The extent of the personnel shortage--both professional and supportive--was demonstrated by the fact that one professional staff vacancy was reported for every two positions filled, a budgeted need for 50% more professionals. In supportive staff vacancies, there is one unfilled position for every three employed, indicating a budgeted demand for 33% more.

To emphasize the obvious, these data demonstrate that the availability of funds and budgeting positions do not assure the availability of personnel, even at the sub-professional level.

If we are to attract the people we need, we are going to have to extend more effort, and plan effective programs which include:

- creative approaches to recruitment
- development of career opportunities for supportive personnel
- provide truly competitive salaries and wages
- establish quality training programs

While our personnel problems will unquestionably never be fully solved, we can do much to minimize them if we take adequate steps to provide good training, compensation and genuine opportunities for vocational fulfillment for the people we are attempting to attract.

The education and training of the professional is largely out of the hands of the rehabilitation facility, but it has unique resources and potential capabilities in training of supportive staff. While we can encourage and support educational institutions and the professions in recruiting more students, we can do something directly and immediately with persons not requiring extended theoretical and clinical backgrounds.

The results of intensified recruitment and expanded training facilities for the professional will not bear fruit up to a minimum of four years and up to ten years from now, while the increasing demand for health and rehabilitation services is with us now.

When asked about their additional needs beyond actual budgeted positions for supportive staff, department heads reported that they could effectively use 20% more than were budgeted. They were also asked what percentage of the duties currently performed by professionals could be carried out by a non-professional aide. Responses to this question indicated that 10% to 33% of their current activities did not require their unique professional skills and could be done by others. These are probably conservative estimates, since there is often a tendency to maximize one's own capabilities, and a reluctance to turn loose of functions one is now carrying out as a professional.

A problem illustrated here is the fractional need for supportive staff as related to small (1-3 man) service departments, which are common in rehabilitation centers. On the low side, we would have to have a ten-man staff of professionals to create a new supportive position and, at best, it requires a three-man professional staff to add a non-professional.

This problem can be, and most certainly is, an inhibiting factor in expanding our use of supportive staff. The approach of development of a core training curriculum in basic concepts and services in rehabilitation for supportive staff might allow more flexibility in their assignments and provide a partial answer.

The considerable extent of current use of supportive personnel in rehabilitation centers is documented by the outstanding success, from a numerical standpoint, of our On-Job Training Program, and the data gathered through the questionnaire survey. The survey also reported a high level of effectiveness of supportive personnel in carrying out their duties as evaluated by their professional supervisors and their expressed need for an increase of 50% additional supportive staff. Without question, we are already embarked on more than a trend; a course of action is well-developed and expanding.

Still to be answered are questions such as:

- Are we making the most effective use of supporting personnel?
- As we increase their use, will quality of services suffer?
- What are the most appropriate techniques of providing for their training?
- If present conditions in the job market continue, how are we going to fill current vacancies and fill new positions created?

If we are to provide positive answers to these and the myriad other questions one can raise on this subject, there must be more research, imagination, creative experimentation and positive action.

Our nation is increasingly accepting good health as a basic human right, and we can anticipate that this right will continue to be more broadly interpreted as stated in the World

Health Organization's definition that, "Health is a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity".

To make this right a reality, we must apply our resources and skills in the most effective manner possible. This means that we must not only accept change, which is inevitable, but direct it in channels that will produce the results desired. We must continually question and re-evaluate traditional practices and procedures, to see if they can be made more effective and efficient. We must use our imagination to devise new ways to better accomplish our goals.

The rehabilitation center, in its short history and tradition,is well-prepared and equipped to give leadership and demonstration to answers to these problems. It has pioneered in developing and applying new techniques and programs, breaking with tradition and questioning old standards in its efforts to help individuals adjust to adversity. It continues to operate on the "leading edge" of the social movements and service concepts of our time. In its multiprofessional staff organization and broad spectrum of patient/client population it provides a social-organizational milieu that is ideally suited to generate new ideas, test and demonstrate new techniques, and break through old traditions held for their own sake. We must retain this pioneering, innovative spirit if we are to take a "reality-oriented" approach to our problems of personnel. At best, current approaches are not filling our basic needs, and in many instances we are falling behind.

As a beginning, here are a few questions that could be tested and approaches tried:

1. Conduct studies of activities and jobs actually performed by clinicians to determine if their skills and knowledge have been most effectively used and the extent to which tasks can be done by others. For example, a study by Mott_/[4] reports that physical therapists spend only 50% of their time in direct patient services. We need to know if the other 50% is being spent on activities for which they are equally well-qualified and cannot be done as well or better by other personnel.

2. Review the economic value of a job in relation to qualifications, responsibility and actual pay. One large rehabilitation center recently reported paying 75¢ per hour for aides and orderlies, with concommitant consistent turnover of people who worked for a few weeks or months between better paying jobs. The tradition of low pay and "dead end" jobs in the health-related institutions may be false economy, in addition to the obvious fact that our position openings just aren't being filled.

3. Develop career opportunities through "job ladders" where, through inservice training and experience, personnel have opportunity and incentive to advance in skill, responsibility and compensation. This could include exploration of increased recognition of "equivalencies," experience and inservice training in lieu of formal education and certification.

4. Develop core training programs through which supportive personnel receive training and experience in basic services and concepts essential in rehabilitation programs, providing more flexibility in their utilization and potential for advancement.

5. Explore the extent to which professionals trained in clinical areas are actually spending their time in administrative or clerical type tasks, and evaluate the appropriateness of their training to their actual function. Should the professional be better trained in administration, or is it possible to assign these functions to other individuals who are specifically trained for these duties?

6. Develop closer liaison between training institutions and "service oriented" facilities to promote more realistic and effective alignment of service program demands with training programs and their production of new personnel for the field.

Rehabilitation centers have continually demonstrated initiative and imagination in achieving their dramatic growth and expansion of programs over the past 25 years. We are now facing a new kind of challenge, where the critical problems are increasing for available staff rather than patients or clients; of qualified personnel rather than money to pay their salaries.

I do not have the answers to these new problems, but I have confidence in your ability and will to solve them.

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PERSONNEL PROBLEMS IN REHABILITATION CENTERS

Richard D. Burk, M.D.

The previous speakers have outlined for you the need for trained health workers which our country is presently facing. They further have indicated the trends developing to meet this need. Statistics are available in great quantity to support their contentions. I would like to continue their presentations by extending them to the particular problems of rehabilitation centers as they perceive them and their needs in their efforts to develop solutions.

We in rehabilitation centers know that many of our staffing problems are in part a direct reflection of difficulties of a general nature that are not peculiar to the centers alone, and the answers that are being proposed and offered are applicable to centers as well as other health facilities. For example:

1. The Problem of the One-Sex Field-- Many of the health service professions have been dominated by one sex: physicians by men, and nurses and therapists by women. In part this has been dictated by wage scales, in part by the nature of the work by a particular field, but all too often the reasons for this one-sex domination is nothing more than tradition and custom and both largely based upon outmoded victorian ethics. Efforts are continuing to rectify this but for the most part they have not been of a meaningful or significant degree and,as a result, capable young people continue to be distracted from a field in which they could be of real service.

2. The Problem of Low Salaries -- It is a paradox of our social-economic structure that the professions which are of greatest value are frequently among the lowest paid. This has been true particularly of many of our health service professions. At long last, there now seems to be a genuine concern and consequent effort to remedy this and every hospital administrator and insurance executive is planning his budget accordingly; but past experience tells that the benefits of this with respect to recruiting new people to the field will be long-term at best. It will serve to retain some of the present personnel and prevent them from fleeing to more lucrative fields.

3. The High Attrition Rate-- This is often associated with those fields dominated by the female sex but it does not follow that these people should be permanently lost. Again there have been attempts at solution, some of which are quite interesting. For example, there is a proposal that apartment houses with a built-in baby sitting service be built next to medical complexes and occupancy priority be given to health workers. An additional solution of considerable merit has been the arranging of working hours and schedules to accommodate female health workers, nurses and therapists in particular, who are in between children or who are beyond their child-bearing years but still saddled with home responsibilities.

4. Unequal Level of Care due to Geographical Distribution -- This has been a particular problem with respect to physicians, but more recently it has extended to other professions as well. There have been attempts at solution: forgiveness loan programs to

attract people to remote areas; Traveling Clinics, radio and TV clinic hook-ups with rural hospitals and facilities; but generally the more remote an area the higher salary its facilities have to offer to attract professionals.

5. Job-freezing -- Often professionals feel they are frozen in their particular profession and can advance beyond it only by returning to school and starting all over in the new field. A suggested solution has been to give academic credit toward an advanced degree for years of clinical experience. While laudatory, the universities and colleges have been reluctant and at best slow to accept such an arrangement. Now let me be more specific with respect to certain aspects of rehabilitation centers that place them in a slightly disadvantageous position in obtaining staff.

a. Rehab centers were late to enter the health facility field and, as a relatively recent innovation, they have not contributed significantly to the training of the presently available professionals. They started their facilities by "borrowing" from their sister facilities or, as they put it, by stealing personnel. This has not always placed us in a favorable light, and a perfectly friendly visit to a neighboring facility is looked upon with considerable suspicion. This newness brought with it a certain glamour that enabled many centers to attract personnel initially but with the coming of age and acceptance and the realization by the professional that rehab work can be just as tedious and demanding as that in other health facilities, the glamour has become thin and a little tarnished. To counteract this and to continue to attract personnel, centers have had to offer a wage rate and fringe benefits above that of the sister health facilities in the community with a further antagonizing resulting.

b. Many aspects of center operation are unique and do not lend themselves readily to the heretofore established guidelines or limits which a profession has set for itself. Most of us were trained in a professional vacuum isolated from all else but our own ilk. We were taught little if anything about what the other professions do, much less how to work cooperatively with them. Rehab centers demand an inter-relation of professions and a constant sharing of knowledge and responsibility. We have had to teach this cooperation, as even today there is very little being done by our university teaching programs to develop the kind of inter-relation and knowledge sharing that are the very heart of the rehab program.

c. Services previously distinctive to the centers are being taken over by the hospitals. As recently as one year ago, it was a rare hospital indeed that provided a full-time family counselor or a psychologic service. Such services were usually left to be provided by the outside agencies and not believed to be in the hospital purview. Occupational therapy and vocational counseling were almost non-existent in the GM&S hospital. Now almost every issue of any of the standard hospital journals carries an article relative to the use of these professions in the acute care hospital. The immediate result of this has been greater competition for available personnel and too often the centers come out second best. The long-term effect has been a broadening of the centers' operation. In general, the centers have moved toward the more severely impaired and the culturally disadvantaged -- the so-called long-term or hard core cases. However, such cases usually have increased problems; financial

resources have been exhausted, family unity or identity has been lost, emotional stability has been strained; all of which place an even greater obligation upon the center to be staffed appropriately in order to deal with such problems.

d. Professional isolation exists in many centers. Rehab centers for the most part tend to be small operations. As a result, the professional often finds him or herself alone without the opportunity to share doubts and concerns with a fellow of the same training and background. This restricts the available professionals to those who have sufficient self and professional confidence to work under these conditions.

There is hope, however, and I'd like to illustrate with a particular case in point. Purposefully I have selected a field that is not represented here today and one that is not commonly found in a rehab setting: It is that of Inhalation Therapy.

Inhalation Therapy is a relatively new field of health service, but it is growing rapidly. Its growth has for the most part paralleled the tremendous advances over the past 20 years in the field of Anesthesiology. It is receiving added impetus from the present concern with the high incidence of the chronic lung diseases, Emphysema and Bronchitis. In 1956 the Committee on Public Health of the New York Academy of Medicine submitted to the New York State Medical Society and recommended they submit it to the House of Delegates of the AMA, an outline entitled "The Essentials of Approved Schools of Inhalation Therapy." At that time, ten years ago, the committee had ascertained that there were a total of seven curricula in inhalation therapy in the U.S. and Canada combined. These curricula varied in duration of training from 12 to 24 months; only one had a tuition fee and most offered a monthly wage to students as an added inducement. Requirements for admission varied from a high school diploma to graduation from an approved school of nursing. There was a total of 31 persons enrolled in the seven programs. The program grew slowly at first, and by June 1960 there were still only seven schools; but by June 1962 there were 17 schools and the most recent figure indicates between 32 to 35 schools. Entry requirements still vary from a high school diploma with some requiring 2 years of college and one school limits enrollees to licensed practical nurses. The programs developed initially in hospital settings and for the most part have tended to remain there, but there is a strong tendency to locate them in medical college teaching hospitals and to establish a university or college relationship. A national organization has been developed -- The American Association of Inhalation Therapists sponsored by the American College of Chest Physicians and the American Society of Anesthesiologists with a national membership of approximately 1900, and affiliate groups in Canada and Mexico. The course of instruction has been expanded to 1200 clock hours, 70 of which must be taught by physicians and 220 of which is classroom instruction in theory. Organization membership requires successful completion of a recognized program and one year of experience in a joint commission-approved hospital.

Now the point of this for us here today is that where a need exists and can be demonstrated and where proper and continuing guidance is given, a great deal can be accomplished in a relatively brief period of time to meet that need. The need for professional assistants in rehabilitation centers exists, I can assure you. We believe the proper and continuing guidance must come from the professional organizations involved.

I have enumerated only a few of the problems a rehab center has in obtaining professional staff. They are practical problems and each center administrator attempts to solve them in his own way, for the success of a center's efforts is directly related to its ability to attract and keep competent staff. Our whole reason for being here today is a direct expression of our concern of our ability to provide the clients we serve with a staff capable of meeting the clients needs. We bring our problem to you, the professions. We are asking, "Show us how to staff our centers"; we know you have responsibilities of a broad scope or you wouldn't be here with us. So we also ask, "How can we, the centers, help you?" If you feel the use of Professional Assistants is part of the answer, then "How can we work together to provide well-trained ones of which you will approve?" You professionals are the backbone of our programs and we will not in any way subvert, avoid, or bypass you in developing our programs. In brief, we need help, and what is more logical or, from our standpoint, more desirable than that we should bring our problem to you, the basis of our whole program.

THE TRAINING OF NONPROFESSIONAL PERSONNEL IN THERAPEUTIC INTERPERSONAL RELATIONSHIPS

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THE TRAINING OF NONPROFESSIONAL PERSONNEL IN THERAPEUTIC INTERPERSONAL RELATIONSHIPS *

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In recent years it has become increasingly clear that effective interpersonal skills lie at the heart of therapeutic endeavors aimed at changing people for the better in the broad fields of rehabilitation, mental health, public health, and, indeed, in the broader areas of education and human welfare.

Paralleling this growing awareness has been the realization that the service needs of our society has far outstripped present and projected trained professional manpower. Further, with existing financial resources, even if professional personnel were available, many states and institutions could not support the cost of meeting service demands.

Beyond these considerations, the available research evidence strongly suggests that existing professional personnel are largely inadequately trained in interpersonal skills that have been demonstrated to markedly enhance therapeutic effectiveness.

The current effort of the Arkansas Rehabilitation Research and Training Center to provide training in effective therapeutic interpersonal skills to both nonprofessional and professional personnel in the broad fields encompassed by the term "Helping Relationships," rests upon a large series of studies aimed at identifying effective therapeutic interpersonal skills in successful counselors, psychotherapists, teachers, and parents.

The focus of these studies has been primarily on counseling and psychotherapy since this provided a relatively simplified laboratory for the study of therapeutic interpersonal relationships.

The rapid growth of counseling and psychotherapy over recent decades implies a high degree of effectiveness. It has become a principal part of the rehabilitation process: It is a common tool of clinical psychology, counseling psychology, psychiatry, social work, school counseling, marriage counseling, rehabilitation counseling, vocational counseling, and plays an increasingly major role in the work of parole officers, group workers, recreation and playground workers, physical therapists, antipoverty workers, occupational therapists, welfare workers, nurses, physicians, clergymen, and educators, to name only the major fields.

In spite of its widespread adoption, there exists a considerable amount of hard research evidence which seems to suggest that counseling or psychotherapy, on the average, is not superior to "no treatment." Several years ago, Eysenck, (1960), characterized the efficacy of counseling and psychotherapy by quoting from Galen, the Father of Medicine

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in the promotion of Samian Clay - one of his favorite remedies, thusly: "All who drink this remedy recover in a short time, except those whom it does not help, who all die and have no relief from any other medicine. Therefore, it is obvious that it fails only in incurable cases." A current review of the evidence, (Truax and Carkhuff, 1966), finds that the overwhelming mass of evidence does indeed point to the conclusion that counseling and psychotherapy as it is practiced, on the average does not substantially prove superior to no treatment. This conclusion is based upon studies involving thousands of clients or patients in a variety of settings both in the United States and abroad. Just as clearly, review indicates that while there seems to be no overall average, positive benefit, there are specific, valid data showing that the therapeutic relationship does produce positive effects. It logically follows that, if the therapeutic enterprise has no overall average effect but does, under some circumstances and with some professional personnel, produce positive effects, then there must also be specific incidences in which it is decidedly harmful. A series of studies have recently demonstrated that psychotherapy and counseling can be, and is, for better or for worse.

There now exists a large number of research studies which point to the conclusion that: When counselors and therapists communicate at a high level of accurate empathic understanding, nonpossessive warmth, and genuineness to their human clients, then there is consequent patient improvement; and, when counselors or therapists communicate low levels of accurate empathy, nonpossessive warmth, and genuineness, then there is consequent patient deterioration. These findings of significant behavioral and personality change have been obtained in client populations as diverse as schizophrenic hospitalized patients, neurotic and emotionally disturbed outpatients, college underachievers, and even juvenile delinquents (Barrett-Lennard, 1962; Bergin and Solomon, 1963; Cartwright and Lerner, 1963; Dickenson and Truax, 1966; Lesser, 1961; McNair, Callahan and Lorr, 1962; Rogers, 1962; Strupp, 1960, Struppetal, 1963; Truax, 1961, 1961a, 1963, Truax, Carkhuff, and Kodman, 1965; Truax, Wargo and Silber, 1966; Truax and Wargo, 1965, 1965a, Truax, Wargo and Carkhuff, 1965; Truax, Wargo, Frank, Imber, Battle, Hoehn-Saric, Nash, and Stone, 1966); Truax, et al, 1966.

Further evidence also suggests that accurate empathic understanding, nonpossessive warmth, and genuineness (or authenticity) lead to similar positive and negative consequences in studies of parental effects upon children (Bateson, Jackson, and Weakland, 1956; Baxter, Becker and Hooks, 1963; Bowen, 1960; Cass, 1952; Chorost, 1962; Frazee, 1953; Lidz and Lidz, 1949; Lidz, Cornelison, Fleck and Terry, 1957; and Wynne, et al, 1958); teacher effects upon learning and personality development in school children (Christensen, 1960; Hawkes and Egbert, 1954; Isaacson, McKeachie and Milholland, 1963; Truax and Tatum, 1966; and indeed even in laboratory studies of learning or conditioning (Sapolsky, 1960; Weiss; Krasner and Ullmann, 1960).

More important for our interest today, we have recently been devoting a considerable portion of our energies to translating these research findings into effective training programs for both nonprofessional and professional personnel. I would like for the remainder of our time today to discuss this aspect of our overall research and training program. It seemed likely that if we could successfully specify and measure such elusive interpersonal qualities as accurate empathic understanding, nonpossessive warmth, and genuineness then we might

successfully use those same research measuring instruments in training. Thus, we might be able to provide both nonprofessional and professional trainees with specific examples of high and low levels of these therapeutic conditions, and to give them immediate feedback in their own attempts at learning to communicate these therapeutic qualities.

Before proceeding let us first get clearly in mind the meaning of accurate empathy, nonpossessive warmth, and genuineness. These qualities have been described elsewhere by Rogers and Truax, (1966).

Of these three therapeutic ingredients, genuineness or authenticity is, perhaps, most basic. For a trusting relationship to occur in any human encounter the therapeutic person must act as an authentic person. Theoretically, neither accurate empathy or nonpossessive warmth could function properly without the therapeutic person himself being genuine. For the helping person this involves an honest openness to experiencing within the therapeutic encounter. It means that there is no professional facade, no professional-confessional screen. It means that he is not denying feelings or experiences; that he does not hold himself aloof from a personal encounter. The measurement (Truax, 1962a) of therapist genuineness from recorded psychotherapy sessions uses a scale descriptively specifying stages along a continuum. At its lowest level the scale includes such descriptions as "...there is explicit evidence of a very considerable discrepancy between his experiencing and his current verbalizations," and "...the therapist or counselor makes striking contradictions in his statements ... or, the therapist may contradict the content ... with the voice qualities...". At intermediate stages on the continuum "the counselor or therapist responds ... in a professional rather than a personal manner ... there is a somewhat contrived or rehearsed quality ...". At higher values of the continuum, "there is neither implicit nor explicit evidence of defensiveness or the presence of a facade," and at the highest level "there is an openness to experiences and feelings by the therapist of all types -- both pleasant and hurtful -- without traces of defensiveness or retreat into professionalism ...". In daily life each of us can think of persons who are transparent and genuine, who are what they seem. This is the quality of genuineness.

The second central concept is the communication of a nonpossessive warmth for the other person. Theoretically, warmth serves as a precondition for the therapeutic person's ability to sense, deeply and accurately, the patient's inner experiences and feelings, and is a precondition for the trusting relationship assumed to be necessary for the patient's use of accurate empathy in the process of self-exploration. It involves a willingness to share equally the other person's joys and aspirations or his depressions and failures. It means an acceptance of the other person and his feelings and experiences without attempts to dominate him through this warmth. Nonpossessive warmth does not mean being paternalistic, sentimental, or superficially agreeable. The measurement of nonpossessive warmth (Truax, 1962) specifies a continuum involving at the lower range such helping behaviors as (he) acts in such a way as to make himself the locus of evaluation ... (he) may be telling the patient what would be "best" for him, or may be in other ways actively trying to control his behavior, or, the therapist "responds mechanically to the client and thus indicates little positive warmth ... or ... ignores the patient where an unconditionally warm response would be expected -- complete passivity that communicates a lack of warmth." At very high values "(he) clearly communicates a very deep interest and concern for the welfare of the patient. Attempts to dominate or control the patient are for the most part absent ... except that it

is important that he (the patient) be more mature ... or that the therapeutic person himself is accepted and liked," or "at the highest level ... the patient is free to be himself even if this means that he is temporarily regressing, being defensive, or even disliking or rejecting the therapist himself."

The third central ingredient of therapeutic encounters that change people, that of accurate empathic understanding, requires of us that we be listeners, thinkers, and talkers. It involves both a sensitivity to what the patient is currently feeling or experiencing, and the verbal facility to communicate this understanding in a language attuned to the patient's current feelings. The accurately empathic therapeutic person not only indicates a sensitive understanding of the patient's apparent feelings, but goes further to clarify and expand what is hinted at by voice, posture, and content cues. The Accurate Empathy Scale (Truax, 1961b), defines a continuum which specifies at its lower values such behaviors as "(he) seems completely unaware of even the most conspicuous of the patient's feelings. His responses are not appropriate to the mood and content of the client's statement and there is no determinable quality of empathy, hence no accuracy whatsoever." Whereas, at intermediate levels of the continuum he often responds accurately to more exposed feelings. He also displays concern for more hidden feelings which he seems to sense must be present, though he does not understand their nature." Or, "he shows awareness of many feelings and experiences which are not so evident ... but in these he tends to be somewhat inaccurate in his understanding." At the higher levels of the continuum of accurate empathy, the therapist "shows awareness of the precise intensity of most underlying emotions ... his responses move only slightly beyond the area of the client's own awareness, so that feelings may be present which are not recognized by the client or therapist," or, "accurately interprets all of the client's present, acknowledged feelings. He moves into feelings and experiences that are only hinted at ... and does so with sensitivity and accuracy. (He) offers additions to the patient's understanding so that not only are underlying emotions pointed to, but they are specifically talked about." To both accurately predict and effectively communicate what the client or patient is currently experiencing and feeling and, therefore, of "what the patient might well say, were he more open and less defensive," is the quality of accurate empathic understanding.

The majority of the research studies assessed the levels of empathy, warmth and genuineness by the use of these research scales developed for use with tape recordings of actual counseling or psychotherapy. As was suggested four years ago, (Truax, 1962), the rating scales themselves can be used in a didactic manner for training beginning therapists. An approach to training, using the research scales in an integrated didactic and experiential program, has been described (Truax, Carkhuff, and Douds, 1964). This training program has been applied to several training groups, both at professional and nonprofessional personnel levels.

The three central elements in the training approach can be summarized as: (1) A therapeutic context in which the supervisor communicates high levels of accurate empathy, nonpossessive warmth, and genuineness to the trainees themselves; (2) A highly specific didactic training using the research scales for "shaping" the trainees' responses toward high levels of empathy, warmth, and genuineness; and (3) A focused group-therapy experience which allows the emergence of the trainee's own idiosyncratic therapeutic self through self-exploration and consequent integration of his didactic training with his personal values, goals, and life style.

While a complete description of the training program is contained in a forthcoming book developed specifically for use in training and practice, (Truax and Carkhuff, 1966), a few brief comments about the use of the research scales should help to clarify the didactic nature of the training. The scales are used to identify tape-recorded samples of experienced therapists who are, in fact, offering very high levels of therapeutic conditions, thus, providing models for imitation. It should be remembered that even the best recordings of total sessions usually provide a number of examples of precisely what not to do. Secondly, the trainees are taught the use of the scales so that they will learn to identify high and low levels of empathy, warmth and genuineness in their own therapy and in that of others. Thirdly, "empathy training," "warmth training," or "genuineness training," is provided by placing a tape recording of patient talk and then requiring trainees to make immediate "therapeutic responses" which are immediately rated on the research scales to provide prompt feedback. As they "shape" their responses toward higher levels of empathy, warmth, and genuineness, they begin role playing which, in turn, is recorded, brought to class, and rated by the group of trainees on the research scales. Thus, they compete among themselves in ability to communicate these therapeutic conditions. Finally, they begin one-shot interviews with real clients which again are tape recorded and brought to class sessions for rating.

In all, the complete basic training program involves less than 100 hours of training.

In the original pilot effort, a group of unselected volunteers from the staff of Eastern State Hospital, Lexington, Kentucky, served as the trainees. At the original meeting, eleven persons volunteered to begin the program. However, by the end of the second week this had dropped to the five trainees who completed the program. Since class sessions were held on Tuesday and Thursday, nurses and attendants discovered that this would involve their coming, even on "days off" without pay. Since slightly over half of the original volunteers dropped out for this reason, it's likely those remaining were highly motivated. The five trainees consisted of three aides, a volunteer worker, and an industrial therapist. Only the industrial therapist had college training while one of the attendants had only two years of high school training. The trainees, as a group, then were untrained in knowledge of psychopathology, personality development or dynamics, but had considerable firsthand knowledge of the everyday behavior of hospitalized patients.

Evaluation of the trained lay mental health counselors focused first on their ability to communicate high levels of accurate empathy, nonpossessive warmth, and genuineness. Post-training; the trainees were given two randomly selected patients for therapeutic interviewing. Samples were randomly selected from these tape recorded interviews and compared with recordings obtained from a contrast group of graduate students in clinical psychology and counseling who had had similar training, and a contrast group of experienced and relatively effective counselors and therapists including such therapists as: Drs. Carl Rogers, Albert Ellis, Rollo May, Julius Seeman, and Carl Whitaker. While the patient population for the lay mental health counselors and post-training graduate students was identical, the patients seen by the contrast group of experienced therapists tended to be less disturbed, more verbal, more educated, and less naive with respect to psychology and psychotherapy.

In terms of the level of accurate empathy communicated to patients, the lay trainees averaged a level of 4.6; the graduate student trainees, a level of 5.1; and the experienced therapists a level of 5.2. These differences, while in the expected direction, did not approach

statistical significance. Similarly, there was no significant difference between the three groups in terms of the level of nonpossessive warmth communicated to their patients; lay trainees averaged scale values of 2.8; graduate student trainees averaged 3.0; and, experienced therapists averaged 3.1. However, with respect to therapist genuineness the experienced therapists showed a significantly higher level of genuineness when interacting with their patients than did the lay mental health counselors; the graduate student trainees did not differ from either the lay trainees or the experienced therapists. Thus, the evidence seemed to suggest that the lay mental health counselors who had had less than 100 hours of training were able to provide minimally high levels of therapeutic conditions.

Further, these psychotherapy recordings from the lay therapists and the two contrast groups were compared in the level of self-exploration achieved in therapy by the patient. A number of previous research studies have indicated that successful cases tend to show significantly more self-exploration than unsuccessful or failure cases. When the patient level of self-exploration was evaluated, differences between those treated by the experienced therapists, the graduate student trainees who had had quite similar training, and the lay mental health counselors did not differ significantly (although the absolute ordering favored the experienced therapists).

These initial findings suggested that lay, nonprofessional hospital personnel could indeed be trained to provide effective therapeutic conditions for severely disturbed patient populations.

Recent studies using the accurate empathy scale throw some additional light on the meaning of these findings. Bear in mind that the lay trainees communicated to their patients an average level of 4.6 on the accurate empathy scale. The first study by Bergin and Solomon (1963) studied accurate empathy from tape-recorded sessions where 18 postinternship students in clinical psychology served as therapists. The six supervisory groups in his sample ranged in empathy from 1.91 to 3.84, with a mean value of 2.50. A second study by Melloh (1964) studied accurate empathy in 28 postpracticum counseling psychology trainees. The average level of accurate empathy was 2.46. The third study was carried out by Baldwin and Lee (1965). Their study used the accurate empathy scale to evaluate a teaching machine program designed for training in effective interpersonal relationships by comparison to informal didactic group therapy. Their subjects were college students enrolled in abnormal psychology courses. The average level of accurate empathy for these college students, prior to the training experience, was 2.55. The teaching machine approach caused no change while the didactic group therapy experience produced significant improvement (a level of 3.2 post-training). Note that all three studies reported levels of accurate empathy significantly below the 4.6 level achieved by the lay therapist trainees. Does this suggest that the major training institutions where the Bergin and Solomon study and the Melloh study were completed are relatively ineffective in their training program? Perhaps. It is significant that the Bergin and Solomon data and the Melloh data both show no significant relationship between level of accurate empathy and graduate school grades, or even practicum grades. In fact, there were nonsignificant, negative relationships in spite of the fact that supervisor judgments of therapeutic effectiveness of trainees showed a significant positive correlation with the measured level of accurate empathy.

A later study (Truax and Silber, 1966), with 16 professional trainees showed significant positive change on accurate empathy and genuineness, but not warmth, over a two-month period during training. Also, there was significant positive personality change on dimensions previously shown to correlate with empathic skill (Bergin and Solomon, 1963).

Thus, it appeared that the lay mental health counselors were able to provide a level of therapeutic conditions only slightly below that of experienced therapists and considerably above that of experienced therapists and considerably above that of postinternship clinical psychology trainees and postpracticum counseling trainees. A further and crucial question remained: could these lay mental health counselors actually prove therapeutic in producing patient benefit with the chronic hospitalized patient?

To evaluate this, 150 chronic hospitalized patients from Eastern State Hospital, Lexington, Kentucky, were selected from the available population so as to exclude mentally retarded and organic patients and those already receiving any form of psychotherapeutic treatment. The variety of current diagnoses included manic depressive reactions, psychotic depressive reactions, and schizophrenic reactions, with the great majority of all patients diagnosed as hebephrenic, paranoid, or chronic undifferentiated schizophrenic types. The total population of 150 patients was randomly assigned with 80 patients receiving time-limited group counseling from the lay mental health counselors who were supervised on a once-weekly basis, and 70 patients serving as controls. The treatment and control groups did not differ with respect to age, years hospitalized, education, etc. On all such variables the absolute differences favored the control group. Thus, the treatment group averaged 50 years of age with the control averaging 47 years; the treatment group and the control group both averaged slightly over 7 years of formal education; both treatment and control groups averaged two admissions per patient, while the correct hospitalization alone averaged 13.6 years for the treatment group and 10.0 years for the control group. In summary, the population was essentially an undereducated, older, quite chronic one. While the sample was a severely disabled one, it represented the great bulk of the hospital population in nonurban state hospitals.

The trained lay mental health counselors met with this older, undereducated, and quite chronic population on a twice-weekly basis for three months of time-limited group counseling. Patients were randomly assigned either to treatment or control groups. The lay counselors continued to meet for supervision once weekly throughout the group counseling period.

Since reading ability was below the fourth grade level, the use of psychological paper and pencil tests such as the MMPI were possible in less than 25 percent of the control and treatment population. To obviate this problem, ward behavior ratings were utilized. Nursing personnel on the patient's own ward (which was different from the wards where the lay therapists worked) made all ratings of patient behavior change. Research evaluation (Carkhuff and Truax, 1965), indicated highly significant differences in (1) overall improvement, (2) improvement in interpersonal relationship, (3) improvement in self-cares and self-concern, and (4) improvement in emotional disturbances. In terms of overall improvement, those treated by the lay mental health counselors showed over 50 percent improved, and almost 50 percent unchanged, with only one showing deterioration. By contrast, less than 30 percent of the control group improved, while approximately 50 percent were unchanged and almost 20 percent showed deterioration.

Since pre and post ratings of ward behavior were used as the measure of change, biased reports from the ward staff should be considered. We have long been somewhat suspect of reported improvement when the ward doctor treated patients and asked the ward staff to evaluate his effectiveness. However, the lay counselors in the present study had no direct contact on any of the wards involved. Further, the ward staff at the hospital was initially resistant to the idea that hospital attendants would be allowed to conduct group counseling. The lay therapists did not initially enjoy high status. Thus, the admitted and outspoken bias of the ward personnel against the use of lay attendants would suggest that any biasing in the ratings might more likely be against rather than for the effectiveness of lay group counselors.

Since the lay group counseling sessions with the hospitalized patient were recorded for supervision purposes, a further research analysis was possible (Truax, Silber, and Carkhuff, 1966). The levels of accurate empathy, nonpossessive warmth, and genuineness actually provided during group counseling with the chronic hospitalized patients was evaluated, using the research scales. These values were compared with those obtained by sixteen experienced therapists giving time-limited group therapy to a somewhat less chronic hospitalized population. Although the average level of therapeutic conditions provided by the experienced psychiatrists, psychologists, and social workers was slightly higher than those of the lay mental health trainees, it is significant to note that 31 percent of the sample of experienced professional therapists provided levels of accurate empathy and nonpossessive warmth at or below that of the beginning lay therapists. When the patients seen by lay mental health counselors were divided into those receiving relatively high conditions, those receiving moderate levels of conditions, and those receiving relatively low levels of conditions and compared them to the control population, the following were obtained: Patients in lay group counseling receiving relatively low levels of therapeutic conditions showed no benefit of group counseling in comparison to the control group; patients receiving moderate or high levels of accurate empathy, nonpossessive warmth and genuineness during lay group counseling showed improvement considerably beyond that seen in the control populations on all measures of patient outcome. Further, there were no significant differences in outcome between patients receiving high and patients receiving moderate level of therapeutic conditions.

These latter comparisons between levels of therapeutic conditions and outcome tend to argue for the lack of bias and for the validity of the ward rating evaluation procedure: The ward personnel themselves could not possibly know the level of conditions actually provided by the different lay group counselors, yet the clear and statistically significant findings indicated differential outcome within the overall improved treatment group, according to the levels of conditions actually provided during group therapy.

A fourth study by Berenson, Carkhuff, and Myrus, (1965), studied the effects of the present approach to training on undergraduate dormitory counselors. In that study, 36 student volunteers were randomly assigned to three groups: 1) the training group proper; 2) a control group which spent the same total number of hours in number training with a program that involved neither the research scales as didactic instruments nor the quasi group therapy as an experiential aspect of training; and 3) a control group which had no specific training in therapeutic practice. The findings from that study indicated significantly greater change (p. 05) on each of the therapeutic conditions for the trainees receiving the total training program as measured by one inventory filled in by a standard "client" who was

interviewed by all trainees and by another inventory measuring the counselor's perceptions. Furthermore, the trainees receiving the total training program showed the same significant superiority over both control groups,(p. 05) when the measure of the level of therapeutic conditions was obtained from their dormitory roommates.

In a further study of 16 graduate students in clinical and counseling psychology, Truax and Silber (1966) cross-validated the earlier findings and extended the study of the effects of the current approach to training by taking "in therapy" measures early and late in the training program. Before the early interview, the trainees had received 14 class hours of instruction and had spent an average of 11 hours listening to tape recordings of psychotherapy prior to the early interview so that the trainees were, at that point, able to provide moderately high levels of therapeutic conditions (since real patients were used for the interviews, it was felt necessary that the trainees have some minimal training to lessen the chances of their actually harming the client). The "late" interviews with real clients were made after an additional 34 hours of training. The level of accurate empathy obtained in the "late" interview averaged 4.50 for the 16 trainees, the level of nonpossessive warmth averaged 3.87 and the level of genuineness averaged 3.74. Thus, the data tended to confirm the earlier findings with a further population of trainees. It should also be noted, that in that replication different instructors or supervisors were used in applying the present approach to training. More importantly, that study evaluated the amount of change from early to late in the training program. The obtained findings indicated a significant increase in the level of accurate empathy (p. 05) and in the level of genuineness (p. 01), but a nonsignificant improvement in the level of nonpossessive warmth.

A further study on the same 16 trainees by (Truax, Silber and Wargo, 1966) also indicated a significant degree of positive personality change in the graduate students undergoing the present training program.

Taken together, then, the available evidence, while more meager than we might hope for, strongly suggests positive benefit for this new approach to training. In light of the Bergin and Solomon (1963) and the Melloh (1964) data, indicating little positive effects of existing training programs, the available evidence just reviewed seems even stronger.

Selection of Trainees

Although both the available evidence and the viewpoint of this approach to training both agree in suggesting that essential therapeutic skills can be learned, it must also be clear that one way of producing more effective therapists or counselors is to be more selective in reviewing prospective trainees.

Ordinarily, supervisors in counseling and psychotherapy tend to select potential trainees on the same bases that they select patients or clients: intelligent, verbal, well-motivated, high socioeconomic status, high ego-strength, etc. In part, current selection procedures derive from the fact that solid evidence for selection has been largely nonexistent. A supervisor does not know a "good prospective therapist" from a poor one, except in terms of very private norms and experience.

Some studies, such as that by Combs and Soper (1963), attempted to discriminate between attitudes held by good and poor counselors. Although their findings indicated that better counselors were those who tended to assume an internal rather than external frame of reference in understanding others, who were people-oriented rather than thing-oriented, and who had an optimistic view of man, solid criteria of counselor effectiveness were lacking. In their data, as in most cases, the definition of counselor effectiveness was based upon their supervisors' ratings. The Bergin and Solomon (1963) study, however, did investigate a number of correlates of empathic ability, which seem to have relevance to selection. Their data indicated that within the restricted range of intelligence occurring in graduate school students, there was a nonsignificant negative correlation with verbal intelligence (-30) and, equally surprising, a nonsignificant negative correlation (-18) with the "psychologist" subscale of the graduate record exam. Their findings also indicated that personality was significantly associated with empathic ability: They found negative relationships with test indicators of personality disturbance (such as the Psychasthenia scale and Depression scale as of the MMPI) and positively relationships with measures of personal strength (the Dominance and Change scales of the Edwards Personal Preference Schedule). Also of importance, empathic ability seemed to be negatively related to a cognitive orientation, as measured by in Order and even Intraception on the Edwards Scale.

The study of the 16 students receiving the present approach to training (Truax, Silber, and Wargo, 1966), also yielded some information of suggestive value for the selection of potential trainees. Personality inventories were administered to that group of students before and after training, and were then compared with their learning achievement. That is, using the measures of their actual ability to communicate accurate empathic understanding, nonpossessive warmth, and genuineness early and late in the training program, those students who showed the most gain in ability, were compared on a number of personality variables with those students who showed the least improvement in therapeutic skills. Here, then, the questions posed were, "What kind of trainee benefits the most from the training program?" and, "What personality changes occur in trainees who change the most compared to those trainees who show little gain in therapeutic skill?"

Some of the findings fit well with the Bergin and Solomon (1963) findings. Bergin and Solomon found a negative relationship between Need for Order (on the Edwards Scale) and empathic ability, among the students in the present training program, those who showed the greatest gains in the therapeutic conditions were initially slightly lower on Need for Order than those who showed little or no gain, and they showed a significant drop in post-training, while those who showed the least improvement in therapeutic skill showed no change in Need for Order. The Bergin and Solomon data showed significant positive association between the Change Scale and Empathic ability; those students who showed the greatest gain in the therapeutic conditions in the present training program were significantly higher on the Change Scale, both pre and post, both before and after training, than those who showed least gain, and there was a nonsignificant tendency during training for the most number improved to increase on the Change Scale and for the least number improved to decrease.

The Bergin and Solomon data indicated a nonsignificant negative association between empathic ability and Abasement on the Edwards and those who gained most and least from the present training program were equivalent on the Abasement Scale before therapy, but

the most improved students showed a significant decline during training, while the students who showed least gain in therapeutic skill showed an increase in the Abasement Scale. The Bergin and Solomon data indicated a positive correlation between the Autonomy Scale and empathic skill; students who showed greatest gain in the present training program started off significantly higher and showed large and significant gain in Autonomy, while the students who showed the least gain started off significantly lower in Autonomy and showed negative change. Finally, the Bergin and Solomon data indicated nonsignificant negative association between the Defensiveness scale on the Edwards and empathic ability; the findings in the analysis of students in the present training program indicated that those students who showed the greatest gain in therapeutic skill were initially significantly lower on Defensiveness, while both groups of students showed a decline in Defensiveness during training. A summary of the findings are presented in Table 33.

Table 33

Summary of Findings on Personality Correlates of Therapeutic Conditions for Therapists

	Bergin and Solomon 1963	Truax, Silber, and Wargo 1966b	
MMPI	Initial	Initial	Direction of Change with Training
Pt scale	low *	low	lower *
D scale	low *	low *	lower *
Mf scale	low	curvilinear * average best	higher *
Ma scale	low	curvilinear * average best	higher *
Si scale	low	low *	lower *
Welsch's A.L. Index	not scored	low *	lower *
Welsch's I.R. Index	not scored	low *	lower *
Constructive Personality Change Scale	not scored	high *	higher *
Edwards Personal Preference Schedule			
N Defensiveness	low	low *	lower
N Dominance	high *	high	lower
N Change	high	high *	higher
N Order	low *	low	lower *
N Intraception	low *	low	lower
N Abasement	low	no relationship	lower *
N Autonomy	high	high *	higher *
N Conformity	low *	low	lower *

* Significant at or beyond .05 level

These findings dealing with initial personality measures for "successful versus unsuccessful trainees" are only suggestive for trainee selection, since both the Bergin and Solomon (1963) and the Truax, Silber and Wargo, (1966) data are based on small samples. However, the agreement between these two studies made with widely different student populations and training approaches is at least encouraging. More importantly, the Truax, Silber and Wargo, data dealing with personality change of students during training in psychotherapy provide evidence that the changes in ability to communicate therapeutic conditions made during the present training program were not "only skin-deep." Those students who showed significant gains in therapeutic (or interpersonal) skills also showed relevant, positive personality change.

Where are we going from here? The evidence seems relatively solid in suggesting that both nonprofessional and professional personnel can be quickly trained to offer minimally high levels of therapeutic conditions and that this training results in significant patient or client behavioral improvement.

Currently, we, in the Arkansas Rehabilitation Research and Training Center, are analyzing the findings of a six-week training program held at the University this past summer. That program made use of video tape recordings in both training and for evaluation. Although the "hard" findings are not all in, it seems clear that significant gains occurred and, to our surprise, the ability to communicate nonpossessive warmth showed the greatest gain. Since we video-taped the entire training program, we are now in the process of developing 16 millimeter films demonstrating the approach to training as well as the specifics of the didactic and experiential program.

Another large scale study is now ready to begin at the Hot Springs Rehabilitation Center aimed at training virtually all Center staff in these therapeutic interpersonal skills. This study will directly evaluate the effectiveness of training and the resulting client personality and behavioral change across a variety of disciplines involving counselors, nurses, occupational therapists, recreational therapists, etc., etc. Another aspect of that study will be an attempt to evaluate the relative contribution to outcome of two specific aspects of the current training program: The use of focused group therapy for trainees, and the use of The Accurate Empathy Scale, Nonpossessive Warmth Scale, and Genuineness Scale for didactic training.

Another study, now six months old, is aimed at evaluating untrained personnel functioning as counselor aides under three levels of supervision. In this case, the counselor aides were recruited as secretaries and, without training, assumed the varying degrees of responsibilities. Under the minimally supervised condition, the aides were virtually responsible for their clients while under the maximally supervised condition the aides essentially helped the counselor with his paper work and scheduling but did little independent counseling or decision making. At the present time, we are analyzing and continuing to collect data in that study, but it is clear that rehabilitation field counselors and counselors in other institutions report that their clients, that they have sent to the Center, are being satisfactorily handled by the aid of counselors.

Finally, we are now planning to offer a special training program to begin in January, 1967, aimed at training personnel throughout the country who will serve as agency or facility inservice training offices. This training program will be set up for a three-week block of training followed several months later by a two-week block of training. In that study, we will have the chance to evaluate whether or not inservice training officers can transmit their training to other personnel within other institutional or agency settings.

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THE SELECTION, TRAINING AND UTILIZATION OF PERSONNEL SUPPORTIVE TO NURSING IN REHABILITATION FACILITIES AS VIEWED BY THE AMERICAN NURSES' ASSOCIATION

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The American Nurses' Association is the national membership organization of professional registered nurses. The Association functions as a federation of 54 nurses' associations in 50 states, the District of Columbia, Puerto Rico, the Panama Canal Zone, and the Virgin Islands, which, in turn, are composed of more than 800 district nurses' associations working at the local level on the concerns of the Association.

The basic purpose of the American Nurses' Association is to foster high standards of nursing practice to the end that all people may have better nursing care. Policies and programs to fulfill that purpose are established by the membership through representation in the House of Delegates, the highest authority in the Association. The major commitments of the Association are set forth in its platform and committee reports which are presented for consideration at each biennial convention. During the interim, the concerns of the Association are dealt with through the various sections, committees and/or task forces working within established policies and procedures, with periodic reporting to and guidance from the Board of Directors.

The Association's Committee on Allied Nursing Personnel is the group charged with the major task of studying the overall needs and trends in relation to all personnel supportive to nursing in the many settings, including rehabilitation facilities, where nursing services are utilized. In so doing, the Committee has directed its efforts towards establishing policies and recommendations fundamental to the selection, training and utilization of supportive nursing personnel which would apply equally in the ever-broadening field of health care, regardless of the nature of the facility or services offered.

Having served as Chairman of the A.N.A. Committee on Allied Nursing Personnel during the preparation of the publication entitled "Health Occupations Supportive to Nursing," a product of that Committee, much of the content of this paper is based on that publication. (1) Briefly, the publication is an explicit statement from the nursing profession on the overall issue at hand in this conference. It indicates that the American Nurses' Association recognizes the role of the auxiliary patient care worker as a definite component of nursing service personnel. The Association believes that these workers, with adequate training and supervision, can occupy a significant place in a well-organized and efficient nursing service, rendering supportive assistance to registered nurses and licensed practical nurses, contributing substantially to the welfare and comfort of patients wherever they may be.

It therefore should be emphasized here that the A.N.A. maintains that the persons responsible for nursing care should be prepared and licensed either as registered nurses or licensed practical nurses. To make effective and safe use of the auxiliary worker, that individual must function in a team relationship under professional nursing supervision, performing only those tasks that do not require the preparation of an R.N. or an L.P.N.

The functions of the R.N. and L.P.N. are available in printed form from the American Nurses' Association (2) (3), and extensive use of those materials is recommended in planning for nursing services wherever they may be offered.

Since the mammoth task of seeing that nursing personnel at the various levels so urgently needed in all health facilities are adequately prepared is essentially the responsibility of professional nurses, A.N.A. recommends that the top priority in regard to emphasis and use of available funds be given to providing additional preparation for registered nurses. The trainers must first be trained to enable them to carry out their expanding functions, particularly in relation to increasing responsibilities in teaching, supervision, and administration to produce more and better prepared nursing personnel at all levels.

In view of the nation-wide shortage, it is felt that the second priority should be that of a concerted effort on the part of all concerned in the recruitment of professional* and practical nursing students, as well as inactive nurses who might be able to accept full or part-time employment. An effective recruitment program must involve not only members of the nursing profession and staff of the educational facilities, but also employment and school counsellors, other health professionals and community groups.

Equally important to an all-out effort to increase the number of nurses is the need to relieve those already available of all non-nursing tasks in order that they may devote their full time to nursing, an important part of which is the training and supervision of subordinate personnel directly responsible for nursing services. In this connection, particular attention should be given to the advisability of utilizing other workers for clerical, dietary, housekeeping, and messenger services which, in many instances, occupy much of the nurses' time, and for which the nursing service should not be reponsible.

Another concern of A.N.A. is that many "new" health occupations are being introduced by various agencies and groups; and a brief look at the job descriptions for many of the "new" occupations reveals that the duties are essentially those of the nurses' aide, although nurses have not been involved in determining the need for and preparation of these workers. Such proliferation of new titles not only creates needless confusion about work roles, but tends to limit the mobility of the worker by indicating that his preparation has been restricted to a particular area of specialization.

It should go without saying that expediency in the allocation of duties, selection, and training of personnel supportive to nursing is obviously not recommended. Plans are now underway to issue, early in 1967, a second A.N.A. publication which will be devoted to a more detailed description of the role of the auxiliary worker in various areas of nursing service. These workers are presently employed under many different titles such as attendant, orderly, nurses' aide, psychiatric aide, geriatric aide, home aide, etc. A.N.A. recommends the use of the title "Nurses' Aide" for all such personnel - not only to indicate the commonalities in duties and training, but to improve the mobility and future employment opportunities of these workers.

* The term "professional" here includes all those in programs preparatory to registration as a nurse.

In general, the role of the nurses' aide is that of assisting the Registered Nurse or Licensed Practical Nurse in the nursing service in the particular type of health facility the service is offered. In this connection, the A.N.A. publication on standards for nursing services (4) should be utilized in determining the need for and utilization of various levels of nursing personnel. It is only reasonable to assume that supportive nursing personnel can be expected to function adequately if their tasks are relatively simple and are delegated by an R.N. and performed under the direction of a registered nurse or a licensed practical nurse. In brief, the nurses' aide's duties should be limited to assisting with the personal care of individuals who are ill or otherwise disabled, and assisting in the maintenance of a safe and healthful environment. In no sense should the aide be expected to work without such direction or to substitute for a Registered Nurse or a Licensed Practical Nurse.

That there is urgent need for a substantial upgrading in salaries and other conditions of employment for all nursing personnel is apparent to all concerned, and A.N.A. recommends that immediate attention be given to this important facet of the total problem of recruitment and retention. The economic security of nursing personnel, like that of other comparable groups, is not one to be considered in isolation; but, rather, should be a joint effort involving the workers themselves, administrators of health facilities, appropriate governmental agencies, and the public.

Suffice it to say here that the health professions, and the facilities offering services, can ill afford to continue the search for solutions to the health problems that so often accompany poverty, if they must depend so heavily upon a sizable segment of the poverty group as workers in the supportive occupations in the health field - not to mention the near-poverty situation of many R.N.'s in the country.

Minimum standards for the position of nurses' aide now vary throughout the country according to the labor market and conditions of employment for these workers. It is not unusual for nurses' aides to be among the least well-qualified, and therefore in the lowest economic group in many communities. Many of these people are therefore caught up in this vicious circle and the turnover is high.

Although the qualifications of aides in nursing services are not easily defined, it is generally agreed that such workers should be screened as carefully as possible as to: a genuine interest in working with people and being of help to those who are ill or disabled; positive attitudes towards work responsibilities; appropriate appearance, speech, and personal hygiene; ability to understand, read, and to write English legibly; good physical and mental health; educational ability to enter the ninth grade and motivation to seek further education; and, evidence of potential for nurses' aide work as indicated by successful completion of appropriate vocational aptitude tests, such as the test for Nursing Assistants prepared and used by the Veterans Administration hospitals.

A minimum and maximum age is difficult to establish firmly because of many factors, and A.N.A. offers no recommendation on this presently. The maturity of the individual, the conditions of the work situation, the possibility that the training might be part of a work-study program for high school students, or other reasons, should be considered in determining the appropriate age range for each facility where nurses' aides are employed.

With reference to training, it is the belief of the A.N.A. that nurses' aides should be given their introductory preparation in a broad-based educational program which is common to supportive personnel in all of the health occupations. Such initial training could serve as an introduction to the nature and purpose of care in the many different kinds of health facilities, the variety and description of available jobs, and an evaluation of the individual's interest and potential for the area of employment preferred.

It is further recommended that such a broad-based educational program be conducted under the auspices of a non-profit educational institution. The program could be adapted to the high school level as an elective course of study, with a correlated work experience to introduce students to employment opportunities in the health field, and could serve as a screening process for selecting nurses' aides or personnel supportive to other disciplines.

One of the most important aspects of such an overview of the health field should be wise counselling to encourage students to undertake the highest possible level of training. Too often, individuals are wrongly encouraged into training for low-level positions with low wages, and less opportunity for advancement and limited service in the health field. As previously mentioned, the turnover among nurses' aides is high and many reasons are offered for this, in addition to the economic status of these important workers.

The A.N.A. believes that applicants for the position of nurses' aide should be advised that such a position requires training and that the individual interested in working as a nurses' aide should be ready for such training, regardless of the auspices under which the training is to be given. The use of the term "training readiness" is encouraged, for it means that the applicant has the necessary qualifications to enroll in the initial portion of the nurses' aide program. This is different from "job-readiness" in that the individual is ready for employment at the time of application, having had the necessary initial training. There is heavy emphasis in the Youth Corps and other facets of the poverty program to prepare the participants for "training readiness," a necessity for any kind of work preparation.

Pre-employment education and continuing on-the-job training of aides is considered essential by A.N.A., just as it is for all other nursing service personnel. Such preparation should be geared to the responsibilities of the nurses' aide in an organized program of combined classroom and related clinical experience. It is further recommended that such training programs be under the jurisdiction of non-profit training agencies, such as the public vocational system. This recommendation is in accordance with A.N.A.'s belief that all nursing education should be under the jurisdiction of educational facilities in the interest of all concerned.

The length of time and content of the training for nurses' aides are questions that must be answered on the basis of the characteristics of the nursing service in which the aide is to be employed. In the psychiatric hospital, for example, the aide functions quite differently than he would in various rehabilitation centers, and it therefore is not practical to say that all aides should have a two-week or a six-months course. However, A.N.A. does question the advisability of extensive pre-employment or pre-service training programs for nurses' aides. From the worker's point of view, the occupation, in most situations at least, is one of limited scope. As management looks at it, a lengthy training period is too expensive due to the rapid turn-over among those workers.

There are many inquiries about recommended training guides for nurses' aides and there is considerable material available. For example:

> Handbook for Nurses' Aides in Hospitals - American Hospital Association (prepared by the Public Health Service, U.S. Department of Health, Education & Welfare, and the National League For Nursing)
>
> How to be an Aide in a Nursing Home - American Nursing Home Association (prepared by Public Health Service, U. S. Department of Health, Education & Welfare)
>
> Test Reservoir for Aide Instructors in Nursing - TRAIN - National League For Nursing

Some very feasible guidelines for the training of nurses' aides have also been prepared by several state nurses' associations, working in collaboration with state boards of nursing, hospital associations, vocational, and adult education departments.

Other recognized agencies, such as the New York City Department of Hospitals' Nursing Services and the Cornell Medical Center, in cooperation with the New York Hospital, have well-designed plans for training auxiliary nursing personnel that are worth looking into.

Textbooks, as such, written expressly for aides are not plentiful, and opinion is divided as to their use due to the variety of situations in which the aide may be employed. Much helpful material, however, may be found in such publications as:

> A Textbook for Nursing Assistants, by Gertrude Cherescavich (C. V. Mosby Co.)
>
> Nurse's Aide Study Manual, by Mary C. Abdallah (W. B. Saunders Co.)
>
> The Psychiatric Aide, by Alice M. Robinson (Lippincott)
>
> Guidelines For The Practice of Nursing on The Rehabilitation Team - American Nurses' Association

It should be understood, however, that although the aforementioned material can serve as guides, the agency responsible for the formulation of content and method for nurses' aide training should do so in collaboration with professional nursing service administrators and educators in the health facilities where the nurses' aides are to be employed.

In regard to placement, it is recommended that only those aides who have successfully completed the required pre-employment training should be employed. Therefore a just and feasible plan for evaluating the job-readiness of the nurses' aide is an essential part of screening for employment. It is further recommended that these workers be employed only in those facilities that provide:

(1) An organized plan to orient the new worker to the specific job situation to which he is assigned;

(2) Continued planned on-the-job training to assist the nurses' aides in the performance of their duties, as a part of the staff development program for all personnel in the facility; and

(3) An adequate number of registered nurses to delegate the tasks to be performed by the practical nurses and aides, and, to supervise and evaluate the performance of those workers.

Estimating the number needed is probably the most difficult part of the total problem, for there is no one formula that can be considered adequate for all types of facilities. In most areas, there is a serious shortage of registered nurses, licensed practical nurses, and trained nurses' aides; and, present indications are that the demand for more in each of these groups will continue as the demand for more and better health care continues to spiral upward.

Many long-range and short-term studies sponsored by professional nursing in collaboration with government agencies and educational institutions, have been made to determine the amount and quality of nursing care needed in established, as well as newly developed, patient care units. Current nursing research continues to produce data which can be useful in constructive planning for present and future use of resources and manpower in improving health care for the public. (5)

Recent research has indicated that the number of personnel staffing a particular agency should not be the only consideration in planning patient care. Quantity cannot be equated with quality. Staff training and skill are the major factors affecting quality of care. It has also been established that the quality of medical care, as well as nursing care, is substantially improved wherever there is a relatively high proportion of registered nurses and licensed practical nurses, in comparison with the number of aides on the staff. (6) (7)

The Surgeon General's Consultant Group to study nursing needs and resources in the U.S. in 1962 (8) observed that the total number of practical nurses and nurses' aides employed exceeded the number of registered nurses. In the analysis of needs, the Consultant Group expressed the judgment that 50% of the direct care of patients in general hospitals should be provided by registered nurses, but no estimate was stated for other facilities where nursing services are provided.

In the light of the expected supply of nursing personnel, the Surgeon General's Group indicated that a more reasonable goal for direct services to patients would appear to be an average of: 38% registered nurses; 30% licensed practical nurses; and 32% nurses' aides. The nursing profession expressed deep concern about that proposal for the well-known reason that, once such a ratio is established as a feasible goal by an expert body, it may tend to become the ceiling, rather than the minimum for safe nursing care - quality care being quite a different matter.

The report of the aforementioned Consultant Group further anticipated that there will be about 350,000 active licensed practical nurses in 1970. Such a supply should make possible a considerable shifting of care from marginally trained aides to licensed practical nurses. The American Nurses' Association has exerted much effort over the past many years in establishing sound standards for the preparation, licensure and utilization of practical nurses as important members of the nursing team. Likewise, careful consideration has been given to the role and training of the nurses' aide. The mushrooming of programs for both of these workers, often without deliberation as to community needs, qualified recruits, and prepared faculty, not only threatens educational standards but will continue to increase the imbalance of the ratio between registered nurses, practical nurses, and nurses' aides. It should be stressed again that it must not be assumed that it is acceptable to use these workers interchangeably, since one cannot replace the other without reducing the quantity and/or quality of nursing care.

The Consultant Group to the Surgeon General also estimated a total of 550,000 registered nurses in the country in 1962, and recommended a feasible goal of 680,000 by 1970. Their report went on to predict that, with adequate financial support, the numbers of nurses prepared at the baccalaureate level could reach 13,000 a year and those with master's degrees could be brought up to 3,000 a year. All of these figures represent a sizable increase in each level of registered nurse practitioner. But, unless the overall shortage of nurses is relieved in such approximated proportions, the needed expansion in schools for both professional and practical nursing students and the improvement of nursing services will lag essentially for want of R.N. teachers, supervisors, and administrators.

In summary, it should be emphasized that the primary concern of the nursing profession, as it speaks through the American Nurses' Association, is to meet the total nursing needs of society, providing nursing services which are both adequate and safe. This concern parallels that of the national Job Development Program by the federal government as of February 1, 1965, which stated in part:

> "To assure trained workers to provide needed services at satisfactory wages and working conditions so that the consumer's needs can be met better and more fully."

It is obvious to all that the consumer's health needs cannot be met better and more fully without close collaborative effort involving all of the health professions. The A.N.A. recognizes its responsibility to continue to assess the augmented demands for nursing services; to give direction and leadership in the delineation and utilization of appropriate nursing personnel to meet the increasing needs in all phases of health care; and to assist in setting appropriate standards for the training of such personnel.

Changes, including patterns of staffing and the addition of workers to perform the non-nursing tasks are clearly indicated. On the other hand, caution should be exercised in increasing the numbers and possible over-training of nonprofessional staff whose functions are limited, in the interest of effective and safe nursing care. Expert professional nurse guidance is therefore required to analyze the needs as to the various levels of nursing personnel required for the kinds of care to be given and the training necessary to prepare the

workers to fulfill their respective roles in the nursing team and the total health field competently.

In conclusion, it might well be noted that, in its policies concerning nursing service personnel, A.N.A. concurs in the statement in an article by Margaret D. West (9) in which she stated:

> "Over the past decade there has been a remarkable increase in the number of health workers. Looking ahead, we can expect an increased work force with a higher educational level. We can expect that an increasing proportion of that work force will go into professional and service occupations and substantial numbers of these into the health fields.
>
> "To meet short-term and immediate needs for more pairs of hands, we must rely heavily on workers with relatively small amounts of training. But it should be clear that more marginally trained workers are not the answer from either the viewpoint of hospital management or the hospital patient. If there is to be good service in the years ahead, there must be planning now for the kinds of training programs that will assure enough well-prepared nurses, therapists, technicians, and physicians in 1970 and 1975 and 1980 to give the kinds and amounts of health service that we consider proper and desirable in our society."

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"THE SELECTION, TRAINING, AND UTILIZATION OF SUPPORTIVE PERSONNEL IN OCCUPATIONAL THERAPY"

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Man has learned much from the animal world, particularly in terms of resolving existing difficulties. There are those who pattern their lives after the tall, willowy ostrich; others, like myself, prefer to follow the more lowly breeds. Behold the turtle, he makes progress only when his neck is out!

Time was, when the age of fifty was considered the beginning of the downhill trek toward old age. Happily, in our present concept a half century marks the prime of life - maturity with opportunity for further growth and development. So it is with occupational therapy on the threshold of its 50th anniversary as a professional association: we have come through a period of self-determination of our role in the total health field, we are clarifying the public image of the occupational therapist, we are correcting the misunderstandings which sometimes exist about this treatment area, and we are attempting to fill the gap between the existing number of practicing therapists and the present needs for such services. Along the way we have passed some important milestones such as the establishment of procedures for approval of curricula with the American Medical Association in 1935, the publication of our own professional journal in 1947, the beginning of a 5-year curriculum study in 1958 and, at the end of that same year, the action taken to recognize and train the occupational therapy assistant as a helpmate in filling the increasing demands for our services.

As a result of the rapidly mushrooming expansion of rehabilitation facilities for physically and emotionally disabled people, and because of the mobility of our professional population we have found it difficult to have more than an "educated guesstimate" of our present and immediate future numerical manpower needs. We can speak only in terms of estimates, based on 1) a known (but incomplete) listing of present positions available, and 2) trends in the development of ancillary medical services. Although this paper deals specifically with the training and use of assistive personnel in the occupational therapy departments of rehabilitation centers, a general discussion of the professional population must precede the more specific approach.

At the present time (1966) there are 7,728 registered occupational therapists in this country and abroad. Of these, about 5,000 are active or practicing, with approximately 25% working in the area of psychosocial dysfunction, the remainder employed with physical disabilities and/or various specialties, such as neurological impairments, general medicine and surgery, geriatrics, education, etc. Thirty-one curricula in colleges and universities are currently educating the prospective therapists in baccalaureate and graduate programs. In 1965 there was a total of 520 graduates, all of whom were then eligible to take the national registration examination. Thus, on the basis of this information we have estimated our needs for qualified therapists to be at least between six and eight thousand more during the next five years. Estimates from other professional groups working on general manpower needs have expressed this figure less conservatively; however, it is felt that the important issue at the present time is not to have a specific numerical knowledge of our needs but rather to attempt to close as rapidly as possible the established gap in those treatment facilities where a position is actually unfilled.

Realizing that with our present educational system we could not hope to increase the professional population as rapidly as we should, realizing also that many of the tasks carried on by registered occupational therapists should be accomplished by an individual with less

education and clinical experience, and accepting the fact that the position of the occupational therapist is not threatened but rather enhanced by the presence of a qualified assistant, the membership of the American Occupational Therapy Association in 1959 endorsed the first training program for certified occupational therapy assistants.

According to the definition in the Health Careers Guidebook, [1] "the occupational therapy assistant works under the supervision of the occupational therapist. He helps carry out programs to assist in rehabilitating patients in hospitals and other health care facilities." He performs various functions such as instructing in manual and creative arts, preparing and laying out work materials and supplies, and assisting in maintenance of tools and equipment. He may assist the occupational therapist to fit special orthopedic devices, such as splints and braces, and he may be involved in recreational patient activities. He reports to and consults with the occupational therapist regarding patient progress and possible changes in procedures. Briefly, his services will be used in two categories - preparation and adaptation of material, and patient contact. The more specific the treatment program, the more responsibility must be maintained by the therapist; but, in a general activity program the assistant will be able to assume greater responsibility after consultation with the therapist. In every case, however, the degree of supervision is dependent on the ability and degree of experience of the assistant.

Turning next to the training of the occupational therapy assistant, the candidate must have high school graduation or equivalency. When the American Occupational Therapy Association first concerned itself with the endorsing of the training and certification of assistants there were a number of persons who had been employed as assistants for varying periods of time. Under a temporary Grandfather's Clause, which required a stipulated period of experience, and satisfactory references, these people were certified as assistants. As more training programs were established (in Psychiatry in October 1959 and in General Practice in 1960) the possibility for certification through grandfathering was eliminated. As of April 1966, thirteen training programs had been approved, and there were 853 certified occupational therapy assistants. The certification, which must be renewed annually, permits but does not include membership in the AOTA. We feel that certification is extremely important to the individual assistant both in terms of his own status and in terms of our confidence in him as a means of increasing our professional effectiveness.

Initially, certified OT assistants were trained as specialists in either psychiatry or general practice, the latter for working specifically in geriatrics. As the programs developed, as the general needs for assistants were clarified and the course content was evaluated, it was seen that a combined training program would prepare a more knowledgeable and more adaptable assistant.

Following the demands for increasing the scope of associate arts degrees in junior colleges, two two-year pilot programs have been established by Mount Aloysius Junior College in Cresson, Pennsylvania, and Saint Mary's Junior College in Minneapolis. There are considerable variations in the two programs; in the latter, occupational therapy is part of a core curriculum involving other allied health fields, with a two-year laboratory course fulfilling all the specific theoretical and practical course material for occupational therapy.

[1] Health Careers Guidebook, United States Department of Labor, U. S. Government Printing Office, Washington, D.C., 1965, p. 184.

Several of the graduates of Mount Aloysius have returned to occupational therapy curricula to continue their professional education for becoming registered occupational therapists.

The majority of the training programs have been short-term, ranging in length from 13 to 22 weeks and combining academic work, special skills training and supervised practical experience. Again, there is a great variation in the organization and structure of these programs, and they have been located in different settings - either in an institution which becomes the potential employer for the graduates, or a facility under the auspices of a state or local agency.

Although the purpose of this paper is to deal specifically with the possibility of establishing training programs for supportive personnel in rehabilitation, it is deemed important to give the background of our existing programs as a basis for recommendations for rehabilitation.

Since much of the treatment in physical restoration is on a one-to-one basis with the goal of correcting or improving specific pathology, it involves "controlled interaction with the patient for therapeutic results. The person administering treatment must have sufficient professional training to enable him to evaluate the patient's condition, plan and administer an appropriate program of treatment and report significant response and behavior to the referring physician."[2] This describes the registered therapist; it may be one of the underlying reasons for the relatively small number of certified occupational therapy assistants found in rehabilitation centers to date. There are, nonetheless, in every rehabilitation facility a number of general activity and supportive or maintenance programs where the occupational therapy assistant can readily function with guidance and consultation from the OTR. It is the opinion of leaders in the field that the certified assistant is capable of helping the therapist with segments of specific individual treatment which have been planned and initiated by the therapist and continue to be supervised by him.

This brings out the most important factor underlying the maximum use of supportive personnel in rehabilitation. Here, as in every other area, an assistant is as good as the supervisor permits him to be. The supervisor's own skill must serve to encourage a continual development of the assistant's potential.

The selection of candidates for training may be done by the same techniques used with other technical trainees. The applicants must be between 18 and 55, in good physical and emotional health, with demonstrated interest in working with disabled people.

To our knowledge, specific training programs for certified assistants for rehabilitation have not been established. Very recently, the Committee on OT Assistants[3] established

[2] "Function of Occupational Therapy Assistant", information sheet prepared by the American Occupational Therapy Association, New York: Revised April 1964.

[3] The administration of the AOTA Occupational Therapy Assistants Program is the responsibility of the Committee on Occupational Therapy Assistants of the Council on Standards, with staff assistance from the Education Division, National Headquarters.

a policy that all programs initiated after August 27, 1966 must be combined programs to meet the requirements of the American Occupational Therapy Association. One such program has been approved, another is awaiting approval and three others are well on the way in the development of training programs.

In a very recent proposal a one-year program in a technical school has been submitted and has good prospects of providing training for occupational therapy assistants for all types of treatment programs. As the role of supportive personnel is more clearly defined by all health professions, it is hoped that additional training facilities will be started in a variety of vocationally, technically-oriented educational institutions, possibly with a greater number of core curricula involving several ancillary services.

This increases not only the supply but also the employment possibilities for the certified assistants, since they are neither bound by disability area nor treatment facility. Although it is difficult to ascertain from our listing whether a treatment facility is specifically for rehabilitation, we know that at least six certified assistants are currently employed in rehabilitation centers.

The apparent lag in developing new training programs may be due to a number of reasons. The concept of the occupational therapy assistant is not yet fully understood by many administrators who may on the one hand have greater manpower shortages but may not realize that many of these should be eased by supportive personnel. At the same time there is a fear among some of the professionals that, contrary to the familiar adage, there may be too many Indians and too few Chiefs; in other words, having the certified assistants unemployed because there are not enough registered therapists for supervision. The main issue, therefore, appears to be that of educating the potential employer about the general employment possibilities of the trained assistant in terms of the philosophy of his own institution. The broad areas of self-care, adaptive devices, home-making and recreation, for example, lend themselves readily toward the domain of the certified assistant, as do the developing areas of home care and community geriatric centers. The determining factors of the best possible use are still the capabilities of the people working together for the patient's most rapid rehabilitation.

Even within our own profession there are still those who hesitate to speak too loudly about the certified assistant. However, the philosophy of the believers may be stated as a willingness to give encouragement and assistance to any educational institution or treatment facility interested in establishing a training program for certified occupational therapy assistants, provided their plans meet the requirements of the American Occupational Therapy Association. Since the variation in the existing programs has been a decided asset in the evaluation of the total development, we would invite programs that initiate a fresh approach to the teaching and course content of training programs for supportive personnel.

To many of our allies it has seemed that we have opened Pandora's box by stimulating the development of the assistant programs. We feel, instead, that we have taken Adam's rib to create a help-mate for our own improved performance, not to be tempted into usurping our professional skill but rather, with judicious supervision, wise guidance and open-minded consultation, to live together happily in a professional "paradise" dedicated to maximum patient care.

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PUBLICATIONS BY THE AMERICAN OCCUPATIONAL THERAPY ASSOCIATION

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"Occupational Therapy Assistants"

1. Psychiatry - Training Program Outline, Requirements
2. General Practice - Training Program Outline, Requirements

Physical Therapy Personnel and Their Utilization

Introduction

According to the records in the Association's office, as of May 1965, the American Physical Therapy Association had over 12,000 members in all categories, of these 1,200 were student members. There are an estimated additional 3,000 qualified physical therapists in the United States who are not members of the American Physical Therapy Association. Also, it can be estimated that about 1/2 of these are practicing physical therapy on a full or part-time basis.

APTA membership figures for the period 1930 - 1966 are quite revealing:

1930 - 518)
)
1940 - 1160) do not include
)
1950 - 4031) student members.
)
1960 - 8427)

1966 - over 12,000

It is obvious that the greatest rate of growth took place in the decade between 1940 - 1950, which included the World War II period and a time of large polio epidemics. But even in the next decade the physical therapy population doubled and it would appear that the same also will occur in this decade.

A ratio of one (1) physical therapist to 10,000 population has been proposed as a desirable ratio to reach. On this basis, in 1975, approximately 20,000 physical therapists will be needed or approximately double our present membership. One agency recently estimated that 54,000 physical therapists would be needed by 1975. The basis for this estimate is obscure. Accurate figures are not available, but there are probably hardly 50,000 qualified physical therapists in the world today. Moreover, this would average slightly over seven physical therapists for every hospital in the United States as compared with the present figure at slightly over one.

At the present time slightly fewer than 1,000 new physical therapists are graduating per year. With the opening of new schools and expansion of existing ones, this figure hopefully will rise slowly over the next 2-3 years to over 1,200.

The Association's Placement Service lists about 1,500 budgeted positions for physical therapists. Approximately 1/2 of these require an experienced person to function in the capacity of a supervisor or head of department.

Approximately 6% of the available positions are in rehabilitation centers and about 54% are in general hospitals. It is estimated that about 10% of the members are employed in rehabilitation centers and 50-55% in hospitals.

Utilization of Manpower and Space

There are many barriers to effective utilization of personnel. A few of these are:

Inadequate or poorly planned space, inefficient or outmoded equipment, inadequate administrative support, high patient load - low discharge rate, inadequate planning for continuity of care in the community, ineffective use of professional skills, inadequate numbers or poorly trained or ineffectively utilized supportive personnel both paid or volunteer, missing or inadequate in service training opportunities and opportunities for continuing education, unrealistic patient program planning regarding individual and group activities, over utilization (or under utilization) of existing staff and space, lack of or inadequate supervisory or administrative skills, inadequate supporting equipment and services.

Because of the nature of this workshop only manpower, space, and supervision are examined because of their interrelationship in the area of effective utilization.

Lack of sufficient space or poorly designed space is one of the most effective barriers to proper utilization of manpower. Efficiently planned space benefits both patient and staff.

Certainly the writer has seen deplorable conditions of inadequate and poorly designed space so that it is difficult for the physical therapist to function at all and impossible to function efficiently. There are many examples of departments which, because of physical layout, are impossible to supervise and a nonprofessional worker would be either in a position of jeopardy without this supervision or would of necessity function only in a very carefully limited area. Some space assigned to physical therapy is so small that the addition of staff would take away space allocated for patient care. Other departments are so very large that bicycles should be requisitioned to get from one end to the other. Of necessity, in this type of situation, supervision is delegated to senior or supervisory staff, whatever they may be called in the table of organization. Supervision of personnel in another building or even as far away as 10 miles is quite another consideration.

One of the ever present questions needing an answer pertains to utilization of services and facilities. Are the patients who are referred to physical therapy really benefiting because of their rehabilitation potential (or in spite of it) or are there those for whom this is reassurance that "everything possible is being done" and who probably would do better on a program different from a dynamic physical therapy program such as a supervised maintenance program. It is hoped that the utilization and review committees required by the social security amendments of 1965 may point some directions for study and give some answers to these perplexing problems.

There are many areas of utilization which need exploration in depth. It is urged that each center study the activities of the physical therapy staff in an effort to determine how they may

function more efficiently, how the service can be expanded or improved, and whether there are, in fact, patients who are going without treatment because of the so-called shortage of personnel.

Even services with a full complement of professional and supportive staff do not necessarily function at maximum efficiency and utilization. It would be unfortunate to assume that the mere addition of supportive personnel would automatically improve utilization or the service.

It would seem that the crux of the matter is first to determine whether the physical therapist is being utilized effectively. If not, then the source of the problem should be identified and alternative solutions need to be sought and implemented.

At the present time there is much talk about direct service (including assessment), consultation or advisory, teaching, administration and supervision, as being the four major areas of physical therapists' responsibilities. Definitive data on how effectively and efficiently the physical therapist is functioning in these 4 major spheres of responsibility is extremely elusive. Increasing the manpower pool is not necessarily the answer to effective utilization and meeting patient and community needs. Is the physical therapist still laboriously handwriting or typing his own progress notes because dictating equipment is either not available or he doesn't know how to use it? Is he still scrubbing out whirlpools because administration is unwilling to employ personnel to function at this level? Is he still making patient appointments because there is no clerk to do this job? Does the physical therapist still have to chase down a patient's record because of inefficient systems of transportation of patient records? Or a static medical records department? Are his teaching methods so archaic that he is wasting his time as well as the time of his patients, or families, or the students who are having their clinical experience under his supervision?

Use of Supportive Personnel

Traditionally and historically, by action of its House of Delegates, APTA has supported the use of the nonprofessional worker. Traditionally the duties of this person have fallen into four major categories - clerical, housekeeping, transportation, and patient-related activities.

(in the small center, 1 person often functions in all 4 areas:

(in the larger center these persons function in more circumscribed jobs

In a 1959 (unpublished) study regarding the use of nonprofessional personnel, 77% of all the physical therapists who responded stated that such persons were being used while 89% of those employed in rehabilitation centers reported such use. The ratio of physical therapist to aide in hospitals was 1:1, in rehabilitation centers 1:3. In another unpublished study in 1964, the rehabilitation center which treated both in and out patients had a ratio of 2 physical therapists to 1 aide, while hospitals that had both in and out patients had a ratio of 1:1. Those hospitals that served only in patients had a ratio of 2:1.

It is harder to identify how physical therapists and their supportive personnel are being utilized.

In 1964 the APTA House of Delegates authorized the creation and appointment of an Ad Hoc Committee to study the Utilization and Training of Non-Professional Assistants. The Committee was given rather specific instructions and was to present an interim report to the House in 1965 and a final report in 1966. The House of Delegates in July 1966 accepted the Committee's recommendations for a policy statement regarding the physical therapy aide and continued the Committee for 1 more year. The policy statement as accepted by the APTA House of Delegates follows as Appendix A.

Additional materials regarding the aide training program are currently in the process of preparation and hopefully will be available for distribution in a few months. Agencies who are considering the initiation or expansion of aide training programs are urged to work closely with the local chapter of the APTA. Both groups are urged to be knowledgeable about the employability of the aide level of worker. As the Ad Hoc Committee reported to the APTA House of Delegates in 1965 "it (the training program) is not intended to create another core of workers whose major contribution would be to the unemployed labor force."

In summary, the utilization of well-trained supportive personnel is a method of extending the physical therapy program, provided that there is adequate space and appropriate continuing supervision. Relieving the physical therapist of tasks such as housekeeping, secretarial, transportation will increase the number of patients for which the physical therapist should be giving his attention in providing the skills for which he has been educated.

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American Physical Therapy Association

Appendix A

AMERICAN PHYSICAL THERAPY ASSOCIATION
1790 Broadway, New York, N.Y. 10019

Training and Utilization of the Physical Therapy Aide
Policy Statement

TITLE: Physical Therapy Aide

DEFINITION:

The physical therapy aide is a nonlicensed worker who has completed an on-the-job training program. The physical therapy aide's primary function is to perform designated routine tasks related to the operation of a physical therapy service but may assist with patient-related activities which are predetermined for each patient and assigned by the professional physical therapist.

PREREQUISITES:

1. Age: 18 years minimum.

2. Health Status: Good physical and emotional health as determined by a pre-employment medical examination.

3. Personal Qualifications: History of school and/or work performance which gives evidence of the ability to meet requirements on the job.

TRAINING:

A training program for the physical therapy aide may be established when there is a demonstrated need and reasonable assurance of employment.

1. There shall be active participation of professional physical therapists in the development, implementation, and evaluation of the physical therapy aide training program.

2. The training program shall be located or affiliated with a physical therapy service which meets the criteria established by the American Physical Therapy Association.

3. The training program shall follow the guidelines recommended by the American Physical Therapy Association. An outline to be used for the training of aides is available from the American Physical Therapy Association.

4. Upon satisfactory completion of the recommended training program, the trainee is eligible to:

    a. use the title, Physical Therapy Aide.

    b. perform the functions which are outlined in this document under the supervision of a legally-qualified physical therapist.

SUPERVISORY RELATIONSHIP:

The physical therapy aide may function only with the continuing supervision of the professional physical therapist.

The physical therapy aide may work only in a supervised situation where there is direction, guidance and frequent observation by the professional physical therapist.

DUTIES:

The extent to which the physical therapy aide will participate in the following activities will be dependent upon the organization, structure, and size of the physical therapy service.

1. Operational Activities

a. Maintenance:	1.	follow established procedures pertaining to the care of equipment and supplies.
		prepare, maintain, clean up treatment areas; maintain supportive areas.
b. Transportation:		transport patients, records, equipment, and supplies in accordance with established policies and procedures.
c. Clerical:		perform predetermined general office procedures.
d. Other:		perform special duties as assigned.

2. Patient-Related Activities:

The physical therapy aide shall not interpret physicians' referrals, perform evaluative procedures, initiate or adjust treatments, assume responsibility for planning patient care, nor make entries in the patients' records, but may:

a. assist patients in preparation for and, as necessary, during, and at the conclusion of treatment.

b. assemble and dissemble equipment and accessories.

c. assist patients in the safe practice of activities related to the development of strength and endurance.

d. perform treatment procedures predetermined for each patient by the legally qualified physical therapist and in accordance with the training of the worker.

RECOGNITION:

Recognition of the training of the aide shall be left to the discretion of the training institution.

If a certificate is awarded, it is recommended that the document include a statement to the effect that the aide has been trained to work under the supervision of a legally qualified physical therapist.

Policy statement prepared by the A.P.T.A. Ad Hoc Committee to Study the Utilization and Training of the Nonprofessional Assistant, March 1966 and approved by the House of Delegates, July 1966.

MANPOWER UTILIZATION IN SPEECH PATHOLOGY AND AUDIOLOGY

by
John V. Irwin, Ph. D.
(Statement of American Speech and Hearing Association)

INTRODUCTION

I represent the American Speech and Hearing Association, whose 12,000 members tend to be either speech pathologists or audiologists. Clinically, speech pathologists are chiefly concerned with disorders in the production of speech and language; audiologists, with disorders in the reception and perception of speech and language. These two interests are obviously but two sides of the same coin. Thus, speech pathologists and audiologists combine easily into one profession and function in one organization.

THE MANPOWER SHORTAGE IN SPEECH AND HEARING

The American Speech and Hearing Association is acutely conscious of its responsibilities to the communicatively handicapped. It has studied: 1) the real demand for the services of this profession, that is, the number who are actually requesting services; 2) the potential demand, that is, the number who need these services and may one day be financially able to request them; 3) the real supply, that is, the number in this profession who practice clinically; and 4) the potential supply, that is, the number who, active or inactive, have completed their professional training plus those now being educated.

Unfortunately, this Association cannot accurately report either real or potential demand for or supply of speech pathologists and audiologists. We can document with some accuracy reasonable approximation of the needs for speech pathologists and audiologists under three headings: 1) direct services; 2) education and training programs; 3) research.

SERVICES: After a careful review of the estimates available, the 1959 Committee on Legislation of the American Speech and Hearing Association (1) concluded that: 1) the incidence of speech and hearing disorders be taken as approximately 1.6 percent among children under five; 5.7 percent among children age five through nineteen; 5.1 percent among individuals age twenty through sixty-four; and 5.1 percent among individuals of sixty-five and over; 2) a fair case load for each speech pathologist or audiologist in the schools should be taken as 100; and 3) the suggestion by the Vocational Rehabilitation Administration that, assuming that the needs of the schools were already satisfied, about one speech pathologist and one audiologist are needed for each additional fifty thousand people in the United States.

If the three criteria just cited were applied to the 1965 population in the United States of approximately one hundred and ninety-five million, it may be estimated that during 1965 over three hundred thousand children under five, over three million children age six through nineteen, five million adults age twenty through sixty-four, and one million adults over sixty-five were in need of the services of a speech pathologist and/or audiologist. These figures, which total nearly nine million five hundred thousand, represent roughly five percent of the total population of the United States in 1965. If, following the findings of Linder (2) we use a

three percent figure instead of a five percent, nearly six million individuals would have needed the services of a speech pathologist or audiologist. For the five percent estimate, some 40,000 professionally trained individuals under our present practices would have been needed to provide necessary services; for the three percent estimate, some 24,000 would have been required.

If we project the conservative percentage of 3 percent to future dates, the potential demand for speech pathologists and audiologists will be approximately 27,500 in 1970 and 29,000 by 1975 (3). These figures are based on an estimated total population in 1970 of 207,127,000 and in 1975 of 222,952,000. Present policies of the national government will tend to provide money and administrative personnel to make these increased demands real as opposed to potential. Thus, in the next ten years, not only will the absolute number of people needing this service increase, but the percentage of these people who will know of and be able to afford the service will be significantly greater.

How do these demand figures of 40,000 and 24,000 respectively relate to the number of professionals actually available? In 1965, some 15,000 people were employed as speech pathologists or audiologists. (4) Clearly, the number of trained personnel currently available is woefully insufficient.

EDUCATION AND TRAINING: The growth in number of training programs in this country has been astonishing. In 1959 (1) there were thirty colleges or universities training at the doctoral level and forty at the master's level. Graduate training is now offered in more than 180 institutions, and the total number of institutions actually offering programs at any level is 247 (5). The composite employment demand of these 247 programs is for three hundred and fifty additional full-time faculty members. Unfortunately, at the present time only some one hundred persons per year receive doctorates in speech pathology and audiology.

This most recent survey of our training program shows that over eighty percent of these programs report lack of financial support for students, eighty-eight percent for additional faculty, eighty-nine percent for space, eighty-five percent for facilities, and eighty-eight percent lack of qualified persons for additional faculty. These limitations constitute significant barriers either to initiating or expanding graduate programs.

RESEARCH: The services offered to clients and the education and training offered to students are inevitably limited by the body of knowledge pertinent to the management of speech and hearing disorders. At present, about two percent of the professionally active membership of ASHA declare that their primary work task is research (6). This is a research force of only about two hundred persons.

SUBPROFESSIONALS IN SPEECH AND HEARING

STANDARDS FOR PROFESSIONAL MEMBERS: The American Speech and Hearing Association has consistently set standards for evaluating the competency of its professionally active members. Since 1960, the basic requirements for clinical certification may be classified under these headings: 1) a master's degree or its equivalent in speech pathology and/or audiology; 2) a balanced educational program with emphasis in normal communication

and in the management of disorders of communication; 3) two hundred and seventy hours of supervised practicum; 4) one year of employment experience; and 5) the national examination in speech pathology or audiology. Individuals who successfully complete these steps are eligible for the Certificate of Clinical Competence of the American Speech and Hearing Association in either speech pathology or audiology. These standards are set by the Committee on Clinical Standards and are administered by the Committee on Clinical Certification.

In addition, the American Board of Examiners in Speech Pathology and Audiology has set up definite standards for the functioning of speech and hearing service centers. Registration by the Professional Services Board of the American Board of Examiners in Speech Pathology and Audiology, although requiring as prerequisite that key members of a staff hold the previously described Certificate of Clinical Competence, requires in addition the meeting of certain standards with respect to facilities, record keeping, fees, referral services, professional autonomy, and other aspects of successful speech and hearing rehabilitation.

STANDARDS FOR THE SUBPROFESSIONAL: At the present time, the American Speech and Hearing Association does not officially recognize the subprofessional in the management of speech and hearing disorders. Nevertheless, the Association has recently become interested in the possibility of utilizing such manpower. The Committee on Clinical Standards is now actively studying potential utilization of the subprofessional. Again, at the forthcoming National Convention to be held in Washington in November of 1966, one professional program deals specifically with the utilization of the subprofessional by speech and hearing services in various environments such as rehabilitation and education, and the use of the subprofessional in medicine, dentistry and special education generally. Thus, although it must be affirmed that no present standards exist, it must also be recognized that attention is being given to the problem.

What are the problems relating to the subprofessional as now seen by leaders in this Association? The major problems center around these areas: 1) What can a subprofessional do? Although it has been suggested the subprofessional might administer certain puretone audiometric tests or certain articulation tests or even perform certain clinical functions, no precise spelling out of specific tasks is now available. 2) What degree of supervision is required? Although it is generally recognized that the subprofessional will be working under supervision, the details of this supervision by the fully-trained professional have not been developed. For example, will the basic relationship be one of direct monitoring of the task by the professionally-trained individual, or will the relation be essentially one of relegating rather completely certain specified tasks to the subprofessional? 3) What training should be offered to the subprofessional? At the present time, the Association has policy neither with respect to the amount of training required nor the level at which this training should be offered. Should the training be six weeks of specialized training offered to a college graduate; should it be a two year course offered at a Junior College level; should it be vocational training offered to high school graduates? 4) What institutions should offer such training? Should it be offered only in the program which trains professionally-competent people, or should it be offered in specialized environments? At the present time there seems to be a great deal of interest on the part of Junior Colleges in offering this type of training. 5) How would the subprofessional relate to the profession? Thus, should the subprofessional in speech and hearing

conceive of his role as terminal, or should he conceive of his role as preparatory to becoming a fully trained professional? Closely related to this problem, of course, is the issue of whether he should or should not be a member of ASHA. Many ASHA members feel that he should be part of this organization in order that the public welfare may be protected. Other members of ASHA worry about the dangers of misidentification.

I wish that it were now possible to make a more definite statement about the policy of ASHA with respect to definition of role, degree of supervision, kind and amount of training, and the relationship to the profession of the subprofessional. At the present time, unfortunately, we have not framed these definitions. I do report, however, that the Association is examining all implications of the situation. It should not be concluded, however, that the Association has at the moment committed itself to active involvement with the subprofessional.

OVERCOMING THE PERSONNEL SHORTAGE

The American Speech and Hearing Association is acutely aware that a personal shortage exists in this field and that it will continue to exist during the foreseeable future. What steps, then, have we taken as an Association to relieve this shortage?

To date, because we have been unwilling to reduce our standards, our most active role has been in the area of recruiting additional personnel. The Association has already participated in several recruitment projects, and it will continue to do so. For example, ASHA has just received approval from VRA for undertaking a two-year recruitment program. Such programs have, at least until the present, been aimed at recruiting individuals eligible for full professional training. But, we now contemplate the very real possibility that such recruitment cannot totally solve the problem!

We have taken a second group of steps which has been consistent with our devotion to the ideal of a competently trained, independently practicing professional. This group of steps has sought to make this professional more efficient. For example, as a professional we have endeavored to make greater use of group as opposed to individual therapy. Second, with respect to communicative disorders of children, we have sought to develop diagnostic techniques which would enable us to select certain maturational difficulties from nonmaturational difficulties in order that our limited therapy manpower might be expended on those individuals who completely need it. Finally, there has been increasing emphasis in recent years on the use of automation and programmed instruction, the intent again being to make more efficient use of the fully-trained professional.

Only recently, as an Association, have we considered the use of supportive personnel. Although this consideration is recent, it is active. I am confident that in another two years a more precise formulation of an ASHA policy for subprofessionals will be possible.

CONCLUSION

The American Speech and Hearing Association is acutely conscious of two responsibilities. One is to meet the need for clinical services for the communicatively handicapped. The second is for the maintenance of the quality of these services. As of the present time, if we have not

moved radically in the direction of the use of the subprofessional, it is because of our fear of the possible deterioration of the service. As we face the expanding needs, we have become increasingly concerned with the potential inadequacy of traditional approaches. As an Association, we must now strive, and by all possible means, to meet total needs with improvement in quality of service.

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SOCIAL WORK MANPOWER NEEDS IN REHABILITATION*

by

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Eleven years ago, in 1955, the writer concluded a four-month study of the field of rehabilitation and its implications for social work education, for the Columbia University School of Social Work.

In the course of this 30-page document, the following paragraphs forecast the trend of rehabilitation programs, and social work's connection with them.

> Rehabilitation practice and broadening medical and demographic data indicate that the next few years will witness a marked increase in the elderly section of the population and in the treatment of chronic diseases. Facilities for the curative and rehabilitative aspects of chronic illness have been growing at a marked rate and undoubtedly will be increasingly incorporated in the structure of community health and welfare services, both governmental and voluntary. Hospitals, clinics, institutions, health departments and many other types of agencies will increasingly develop rehabilitation programs as part of their overall medical approach. Because of this growing emphasis and concentration, it becomes important to view rehabilitation as a third aspect of general medical care--along with prevention and cure--rather than as a separate specialized entity. Since the rehabilitation of the patient to improved functioning in activities of daily living inevitably involves an interweaving of psycho-dynamic and social factors with purely physical and medical ones, the increasing significance of this broad development for social work practice and social work education must be underlined.
>
> In the future, most social work programs and personnel will deal with an increasing number of chronically ill, and rehabilitated patients as part of the normal everyday services of the agencies. The serving of such rehabilitated persons in case work and group work agencies, in vocational guidance, in family care and home programs of general hospitals and through a variety of other means, will become much more common than at present. There will probably occur a movement toward the coordination and integration of social rehabilitation services under a particular agency--possibly family

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agencies will prove flexible enough to assume such a role; or it might be assumed by specific disease-structured voluntary health agencies or by public agencies such as Health Departments. For public assistance clients such a role will be assumed to an ever-increasing degree by public welfare departments, whether or not they organize themselves in special rehabilitation units. In the field of vocational guidance training and placement, there will undoubtedly be a continuation and furtherance of the present stress, through public employment and vocational rehabilitation services, on increasing the employability and placement of handicapped and chronically-disabled workers.

An additional element of importance to community planning and social work, lies in being sensitive to the needs of, and offering services for, the mentally retarded in our society. Social agencies and social workers have not generally seen it as their function to serve the needs of retarded children and adults, and their relatives, in the past, but this condition is changing, owing largely to the activities of lay and parent groups. Rehabilitation planning for retarded individuals is increasing, --including vocational guidance, training and placement--and the establishment of special sheltered workshops. The public vocational rehabilitation agencies are increasingly interested in work with such individuals. Retardation is also frequently found as an accompaniment of physical and neurological disorder--e.g. as in cerebral palsy--and thus is more frequently appearing in hospitals, clinics and rehabilitation centers. These facts suggest that it is desirable to include in the general curriculum of schools a broader account of mental retardation as a social, individual and family problem, and of appropriate ways in which social work services may be developed for this group.(1)

In the light of the above considerations, the document developed some recommendations for curricular revisions in one school of social work, to stress the following major subject areas:

A. Work as goal, therapy and focus, including:
Insight into work in the American culture and its meaning to the individual.

Understanding of the structure, methods and requirements of business and industry.

Understanding of the functions required of workers on various types of jobs.

B. Medical aspects of disability

C. The respective approaches and scope of services of the several disciplines in rehabilitation

D. The use of community resources appropriate to the rehabilitation process

E. Case work methods in helping disabled individuals and their families

I have not been connected with the Columbia School for a good many years, and I am unable to say to what extent these well-meant recommendations have been placed into practice. It is probably fair to state, however, that many schools of social work have received similar reports, most having been stimulated by the V.R.A. Some progress has been made, and some

pretty good things have been happening. But by and large the general picture is probably that these suggestions for curricular emphases in social work education, especially those relating to the meaning of work, the requirements of business and industry, and the functions on particular jobs, have been more honored in the breach than in the observance.

These educational considerations are a useful background as we seek to analyze social work manpower needs in the rehabilitation fields. They are especially pertinent when we remember that social work has battled mightily for its professional status, and is still doing so, and that one of its vital weapons has been its rather rigorous and unbending educational standard of the two-year's master's degree with its heavy component of two years of closely-supervised field practice.

Of course, nearly 12 years ago, I did not foresee some of the newer programs that now engage much of social work's attention--especially the re-discovery of the poor in the varied anti-poverty programs, and the expanding community mental health activities. From the stimulus of manpower needs for these important programs, there may come--at least I hope so--a loosening of some of the rigid educational requirements in social work education, and a differentiation of different levels of skill, and of educational preparation appropriate to each.

What can one say about the need for social workers in rehabilitation services, and about the present supply? First, I think we should differentiate between two types of function--the social worker in the rehabilitation center, hospital clinic or other treatment institution; and secondly, the social worker in the usually public vocational rehabilitation programs, functioning as either counselor, supervisor, or administrator.

In November 1965, a task force of the Department of Health, Education and Welfare presented a report on Social Work Education and Manpower, to the Secretary of Health, Education and Welfare, under the title "Closing the Gap in Social Work Manpower."(2) This is certainly the most authoritative document that has appeared on this subject, and I shall quote from some of its findings.

With reference to social work in the health field generally, the report states that only 25% of 6834 hospitals in the U. S. had a social service department at all, and that about 25% of the roughly 9,000 social workers employed in hospitals were not graduates of schools of social work. In 1965, a total of 15,000 social workers or about 10% of all the social workers in the country, are found in the health field, the majority of them in the hospitals and related treatment institutions, and smaller numbers in public health, disease--specific voluntary agencies and in rehabilitation services.

A survey in 1960 found that 2% of the governmental social workers were engaged in rehabilitation programs--and about 4% in voluntary agency rehabilitation activities.

The recent Health, Education and Welfare Report concludes that "the health field is seriously undermanned in social work personnel, that geographic coverage is most uneven, and that the rate growth is so varied that there is an ever-widening gap between needed and available man-power for services that are vital for existing or contemplated programs

of treatment and rehabilitation in physical and mental illness..." (p. 21)[2] Nor do we find, from the same source, a highly significant improvement or accretion from 1950 through 1964. The number of social workers in rehabilitative services did go up, from a total of 1,756 to 2,538, but in the light of present and projected need such an increase is both too little and too late.

What about projections of future need?

While all forecasts are hazardous and subject to unpredictable error, it is clear that rising population and expanding programs of all types will interact to widen the present manpower gap, unless extraordinary efforts are made. The Health, Education and Welfare Task Force estimated a need, by 1970, of at least double and quite probably triple the 6,000 social workers employed in medical hospitals in 1964 (p. 79). A similar projection is made for the public health services, and an even greater increase is suggested as needed in the mental health field.

The Health, Education and Welfare document does not spell out the specific requirements in rehabilitation service. We may assume that the quoted figure for hospitals does indeed include the need for the first category of social workers in rehabilitation service, but it does not consider the needs in vocational rehabilitation. On that subject, most of you are more knowledgeable than I--I can only point to the steadily rising curve of clients rehabilitated by the State agencies; to the increasing emphasis on the rehabilitation of public assistance clients, and of the educationally and socially disadvantaged.

These trends will continue and expand, and we therefore face a rising curve of expectation and need--one that we dare not fail to meet.

Of course a philosophical question obtrudes--it is whether social work is an appropriate discipline in vocational rehabilitation. I appreciate and applaud the great strides that have been made in rehabilitation counselor training programs, in clinical and counseling psychology. I believe that these disciplines have picked up and run with a ball that social work fumbled. But I would still hope there is a place in the public programs for some of the detailed understanding of human behavior and practice skills developed by social workers through arduous years of training and experiment--a place both as practitioners and in other roles.

The position of the chief professional organization in social work--the National Association of Social Workers--has been generally supportive of education and recruitment of social workers for rehabilitation service. In its chief public document, "Goals of Social Policy," published in 1963, the NASW has this to say:[3]

> NEEDS Pending the development of a comprehensive /health/ program for all groups in the population, steps should immediately be taken by government to improve the availability, quality, and quantity of medical care to meet the following needs:
>
> Particular attention should be given to prevention as well as treatment. Specific problems include: (a) the further development of health services for mothers and children; (b) planning and development of services for the health needs of the chronically

ill, including institutional and non-institutional care; (c) planning and development of services for the health needs of socially and economically disadvantaged persons and groups; (d) planning and development of health services in areas of high incidence and prevalence of specific illnesses.

PERSONNEL Serious personnel shortages among physicians, psychiatrists, nurses, technicians, social workers, health aides, and other health personnel, together with the increasing cost of training such specialists, make governmental financial assistance for such education essential. All health services should therefore combine their resources to provide increased financial aid for the following: (a) recruitment, (b) the expansion of educational facilities for preparation of needed health workers, (c) increasing scholarship aid, including educational leave for qualified persons and teaching grants, (d) in-service training, and (e) increasing compensation for health workers. These measures will serve to facilitate recruitment and to hold qualified personnel. Barriers to the preparation of otherwise qualified persons which are based on race, religion, sex, or economic status should be eliminated.

RECOMMENDATIONS:

1. PROGRAM Governmental and voluntary programs of rehabilitation, in terms of both special programs of vocational rehabilitation and rehabilitation services furnished as an aspect of broader health and welfare programs, should be strengthened, expanded, and coordinated in order to provide adequate services to all those who can benefit from them. Legislative authority, both federal and state, should be clearly adequate to make this possible and local rehabilitation programs should be established where needed.

2. SCOPE OF SERVICES Rehabilitation programs should make available to disabled persons, on the basis of individual need, a wide range of services including: (a) comprehensive medical, psychosocial, and vocational diagnosis and evaluation; (b) physical restoration, including medical, surgical, psychiatric, and hospital services, medically-related services, and prosthetic or assistive devices; (c) social services in relation to physical, vocational, psychological, emotional, and social problems; and (d) vocational guidance, training and employment placement, and evaluation. Adequate provisions for meeting basic income needs are essential to effective rehabilitation.

3. FINANCING Adequate governmental funds, including payment from the social insurance system of the rehabilitation costs of insured disabled persons, should be made available to support a full range of services of adequate standards in all parts of the country, and financing should be appropriately shared by the federal, state, and local governments in terms of their relative fiscal capacity and ability to utilize funds adequately.

4. REHABILITATION FACILITIES Construction of physical facilities for rehabilitation programs in general hospitals, chronic disease hospitals, rehabilitation centers, sheltered workshops, and other specialized facilities should receive governmental support. In assessing the need for additional facilities and planning for

construction, there should be the broadest community participation and coordination of facilities on a state or regional basis.

5. PERSONNEL Basic to the provision of effective rehabilitation services is an adequate supply of competent personnel. Serious shortages exist in all the professional fields concerned with rehabilitation such as medicine, nursing, social work, vocational counselling, physical therapy, occupational therapy, and speech and hearing therapy. Public funds should be expended for the expansion of training facilities and strengthening of training programs in educational institutions, scholarship assistance to students and the development of in-service training programs. Public agencies should establish rates of compensation commensurate with the level of professional responsibilities and should provide for educational leave and other staff development measures.

6. RESEARCH Research on the problems affecting rehabilitation and the best methods of solving them should receive support from all levels of government and research fellowships should be provided to increase the supply of qualified research personnel.

7. EMPLOYMENT Employment opportunities should be available to all persons in accordance with their capacities, without arbitrary disqualification related to handicap. When necessary, employment opportunities for handicapped persons should be encouraged through special educational efforts, training, demonstration, and selective placement projects and through sheltered workshops for those not ready or able to compete in the open labor market.

8. CO-ORDINATION To insure continuity and completion of rehabilitation efforts and to prevent duplication, there is need for the closest sustained coordination at all governmental levels of all agencies and groups serving the handicapped, with respect to both program-planning and individual referrals and treatment. Arrangements should be worked out to assure the availability of rehabilitation services to disabled persons receiving public assistance or benefits under workmen's compensation, union or employer disability plans, veterans' programs, or public disability insurance programs. There should also be coordinated planning with respect to measures designed to prevent disability, especially through accidents, and measures directed toward early diagnosis. A qualified rehabilitation agency should take the initiative for coordinating such services and planning.

9. PUBLIC EDUCATION Public education should be directed toward developing a greater understanding of handicapped persons and an acceptance of responsibility for provision of opportunities for the handicapped.

This statement of broad goals will be revised by the Delegate Assembly of NASW in 1967, but will probably not be very different. While all the sentiments are important, social action to implement the recommendations has not been conspicuous, nor effective.

The Council on Social Work Education, the chief coordinating instrument of the schools of social work, has also not helped to alter the prevailing manpower gap in any appreciable way.

Unquestionably the most effective agent for change and overcoming the gap has been the V.R.A., with its program of financial support for social work faculty and students, to increase the volume and effectiveness of rehabilitation teaching in schools of social work.

Unfortunately, a recent report on the training activities in social work by V.R.A. is now in press, but was not available to the writer. I therefore quote from older figures, which show that in 1964 the V.R.A. gave traineeships to 279 social work students for rehabilitation training, and to 28 students for training in services to the mentally retarded. In addition, teaching grants to support faculty in such programs were made to 45 graduate schools of social work, with 8 receiving retardation grants. The sum expended on these programs was close to $1,500,000 in 1964.

While this support is exceedingly important, and may be expected to increase, it touches only some 3% of social work students, and therefore does not materially affect the manpower supply.

In conclusion, it seems to me that the situation calls for extraordinary efforts, at least to triple the number of trainees in schools of social work through government funding. Schools of social work, for their part, may well seek to develop a one-year master's degree, as the only clear road to closing the manpower gap of personnel for the health services, including rehabilitation in its dual aspects.

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THE UTILIZATION OF REHABILITATION COUNSELING SUPPORT PERSONNEL

A Statement of Policy
of the

NATIONAL REHABILITATION COUNSELING ASSOCIATION

Presented by

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Rehabilitation Counseling[1] as one of the helping professions is standing at a critical point in its growth and development. Quantitative and qualitative demands for service engendered by the successes of the past and encouraged by the passage of the Vocational Rehabilitation Amendments of 1965

> "...once again highlights the need for qualified personnel in sufficient numbers to provide the rehabilitation services that are needed by the disabled people of the nation." (1)

How we respond to the challenge of delivering our current and future patterns of services to increasing numbers of disabled people, must be considered NOW!

To accomplish the objectives of expanding the availability of rehabilitation counseling services, attention must be directed first to the current and projected shortages of professional counselors. These have been documented by Smits. (2) He has estimated that by 1970 the State Vocational Rehabilitation Agencies will be required to recruit 787 new counselors annually. In addition, the private agencies will require 250 - 400 new counselors per year. McAlees & Warren (4) note that by 1967 the state agencies will require a total of 5,300 counselors, which is a 104% gain over the 2,600 counselors employed in 1964. Furthermore, with the proliferation of job opportunities indirectly related to rehabilitation, such as in the poverty programs, and in doctoral programs, rehabilitation facilities can expect to be confronted with continuing staff shortages.

In order to meet the demands for counseling services brought about by the Vocational Rehabilitation Amendments of 1954, several universities, in cooperation with the Office of Vocational Rehabilitation, developed graduate programs for the professional preparation of

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1. The term counseling in this statement refers to the relationship between counselor and client"...to assist the client to make the most constructive use of his remaining or restored potentials. The goal of counseling is the re-integrating of the individual into society." (3)

rehabilitation counselors. In 1964, there were 34 graduate schools with curricula in rehabilitation counseling. Despite the increase in the number of graduates from 5 in 1955, to 281 in 1964, with 400 - 450 students graduating annually in 1965 and 1966, the numbers of vacancies continue to grow at a faster rate than the supply of available personnel. With the advent of recent legislation, and the concomitant requirements for additional personnel, plans are being formulated to expand the numbers of institutions of higher learning providing graduate education in rehabilitation counseling. However, the mere addition of more university programs cannot guarantee that sufficient numbers of students will be prepared to meet the anticipated demands for service.

The universities are faced with their own personnel shortages in staffing the existing and anticipated training programs. Sufficient numbers of students must be recruited to enter this profession. The problem of recruitment is particularly acute since all of the helping professions are attempting to attract the same student for graduate school. Facilities and staffs to provide internship experiences for the students are in short supply. Thus it can be expected that the ratio of supply to demand will remain unbalanced for the foreseeable future.

The National Rehabilitation Counseling Association, concerned with the shortages of qualified personnel to provide counseling services, has given careful consideration to its responsibilities in contributing to the solution of this problem.

> "The basic position of NRCA on rehabilitation counseling and support personnel must relate to the Association's professional membership standards, (i.e. must have attained a Master's degree, have one or two year's experience, depending on the nature of the degree, and must be employed in a rehabilitation counseling setting also appropriate to meeting client needs.) Its basic position must also relate to a hierarchy of loyalties stemming from demands and interests which require a viable and durable framework for decisions and operations: client, counselor, profession, agency and university." (6)

An underlying principle guiding the deliberations of the Association is that its recommendations are considered to be guidelines or hypotheses, which when subjected to critical research may provide the present and future basis for the delivery of services to the disabled. While the demand for personnel may be critical, caution must be exercised in the utilization of expedient measures to meet an "emergency" situation.

One suggested approach to meeting the shortage of professional counselors is based on the assumption that there is a direct relationship between the availability of counselors and the provision of counseling. Thus, if more counseling is required, more counselors will be needed, i.e.

More Counselors = More counseling

Within the framework of this premise the primary objective is to develop methodologies to provide sufficient numbers of individuals to perform the counseling function. Ideally this can be accomplished through the expansion of university educational programs and the recruitment of more students. If the personnel needs cannot be met through the university programs,

then consideration must be given to the utilization of individuals with education and backgrounds thought to be related to rehabilitation counseling; such as, teachers, special educators, social workers, etc. This approach is based on the assumption that such individuals can be expected to perform the duties and assume the responsibilities of the professional counselor after appropriate short-term training. While the utilization of the multidisciplinary approach is characteristic of the rehabilitation process, this does not imply that any member of the team can perform adequately in roles for which he has neither the education nor the experience. Grigg (7) found that when a counselor was educated in another discipline, such as teaching, in the counseling relationship he reacts to his clients in terms of his teaching role while the educated counselor reacts in terms of his counseling role. The shift from one role to another can and does occur but is more likely to evolve through formal education rather than through any combination of inservice training and experience. The implication for rehabilitation counseling substantiated by Jaques (8) is that the counselor who has been educated rather than merely trained in the fundamentals underlying the counseling process, is more effective in assisting his clients achieve their unique goals

> "Like...any other educated professional, he (the counselor) must learn specialized procedures and be responsible for their application in light of a broad knowledge of his field." (9)

The U. S. Office of Education, in referring to school counselors, comments that:

> 'There is an increasing recognition of the fact that the counselor's skill and competency should be based on a foundation of basic theory and research.' (10)

This knowledge can best be acquired through the coursework provided in graduate counselor education programs since,

> "...short term training institutes can do little more than scratch the surface of a very complex set of problems." (11)

An extension of the utilization of individuals educated in related disciplines is a consideration of training personnel with less than professional education in any discipline. It is anticipated that such individuals with Bachelor's degrees, or even less, can be trained through a combination of on-the-job training, institutional and university courses to perform some of the "simpler" duties of the counselor as they relate to the provision of direct services to and with clients. The utilization of such persons as counselor aides[1], while not new, has become very popular with the advent of recent social legislation, though without substantial research on outcomes. For example, Harvey (12) has trained volunteers to staff marriage counseling agencies, and the poverty programs use the "sub-professionals" extensively. (In these programs the underlying rationale is not necessarily to provide more professionals, but that the indigenous worker is able to communicate with the recipient of services more effectively than the professional.) The CAUSE[2] program was developed to alleviate the shortage

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1. The use of the term aide within this statement refers to those individuals who are performing duties directly relating to counseling process, e.g. interviewing, determination of motivation for rehabilitation services.

2. Counselor Advisor University Summer Program.

of counselors anticipated in the burgeoning Youth Opportunity Centers. In this program, college graduates were provided with a 6 to 8 week program of training in counseling and guidance at cooperating universities. After the completion of the course, they were to receive subsequent on-the-job training at the YOC's with the objective of employment as counselor aides.[1] At the present time we do not have any data concerning this program to ascertain whether the results are adequate to apply to the use of aides in rehabilitation.

The utilization of the aide in the counseling process implies the provision of the same services by the counselor and aide, differing only in the degree of sophistication. Not only will the public and clients, in particular, tend to become confused but the differential roles of the counselor and aide are likely to become blurred. Even though any recommendation for the use of the aide is generally accompanied by a proscription concerning the necessity of professional supervision, at what point is the decision made as to who does what? How is the decision made and by whom? One suggestion is that the aide can deal with the less complex case such as, helping a paraplegic decide which of several colleges he should attend. While the client's problems and needs may appear to be directly related to the selection of an appropriate school, there may be subtle factors which, when unrecognized and consequently not dealt with, can have a profound impact on his success in school and future life. On the other hand, the discharged mental patient may superficially appear to present complex problems, yet only require selective placement. The ease or difficulty of a case cannot be decided in a vacuum, but arises out of the counseling process and requires the broadest base of understanding, experience and education.

Another problem often encountered in the vertical relationship between counselor and aide is the likelihood of role conflicts between the two. Hahn (13) states

> "...if people with lesser degrees perform our (the counselor's) functions we lose face."

Thus, the professional may feel insecure and threatened in his relationship to the aide. On the other hand, if the aide is unsure of his duties and responsibilities and consequently the skills he must possess, he may feel that his services may have little value in the overall process. This conflict then relates to the differentials in judgment and decision-making and the training and qualifications for doing so. Particularly is this true when job titles are not sufficiently discriminative between levels of judgments to be made and activities to be performed.

From an administrative point of view, while the use of the aide may ease the immediate problem of personnel shortages, certain long-term factors must be considered. If an aide has been employed for five years, and a professionally trained, and recently graduated counselor is hired, is he only to be used until a professionally trained counselor becomes available? If sufficient numbers of college graduates cannot be recruited as aides, will consideration then be given to

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1. The American Personnel & Guidance Association has not endorsed this program--see Pers. & Guid. J. XLIV (Sept. 1965) p. 107

hiring people with less than college training? Are aides responsible to the ethics developed by professional associations, and upheld by the agencies? While safeguards of supervision may be included in the job description, what will the course of action be if the agency loses its professional counselor? Will the aide be laid off until the new counselor is recruited? What are the legal implications in the provision of services by less than a professionally trained person, particularly as it concerns the provision of services to minors?[1] Furthermore, the concept of the counselor aide is derived from a descriptive analysis of what the counselor does, i.e. interviewing, arranging consultations, completion of forms, rather than from an analysis of function in terms of why a service may or may not be required by a particular client. Thus, the utilization of the counselor aide may not accomplish the objective of balancing the equation

More Counselors = More Counseling

Since the primary objective is to increase the availability of counseling, let us now consider the assumption that the counseling process itself contains elements which directly enhance or influence the role and function of the professional counselor. Out of this matrix, recommendations for the effective utilizations of the skills and talents of support personnel may be derived.

There is general agreement that the counseling function will be enhanced through the utilization of individuals who have the capability to support the counseling process through the application of specialized or technical skills. The McAlees-Warren Report (15), The Case-Load Management Guide (16), and the joint ARCA-NRCA meeting at the University of Maryland in July 1966, have agreed that the counselor's talents and skills will be more effectively utilized through the use of support personnel who are able to carry out specific activities essential to the diagnosis of client needs and potentials, and the provision of services which assist that client to achieve his unique goals. Some of the support functions may be:

1. The administration and scoring of aptitude tests performed by a person with a BA who has had appropriate courses in tests and measurement.

2. Job development performed by a person experienced in business or industry.

3. Clerical duties performed by a person with a business school education.

To date, the focus of study and recommendation in the use of support personnel has been directed to the State Vocational Rehabilitation agencies. Since the overall duties and responsibilities of the state counselor are relatively clear, and generally defined by regulation, the factors which impinge upon the effective utilization of counselors can be studied

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1. While the legal question has not been raised for rehabilitation counseling, the Law of Guidance & Counseling (14) suggests some problems which may have implications for the use of aides.

directly. In the private sector, counselors are called upon to perform a variety of duties in a variety of settings. Counselors are employed in hospitals, workshops, medical rehabilitation centers, vocational rehabilitation centers, etc. The Association of Rehabilitation Centers has estimated that there are:

> "....2000 facilities varying widely in emphasis, that identify themselves as rehabilitation facilities."(17)

While counselors are not employed in all of these facilities, over 50% of the agencies studied provide vocational services and, of these, 41% utilized vocational counseling. (18)

In considering the use of support personnel in private agencies, consideration has not been given to the support provided by other professional disciplines such as medicine, social work, etc., nor has attention been directed to the support that the counselor provides to the other disciplines. The lateral relationships between these disciplines is characteristic of the comprehensive approach to rehabilitation. However, within the framework of the counselor's functions it is possible for the specialist to accommodate more than one counselor, more than one discipline, or even more than one agency.

While it is recognized that the counselor's specific day-to-day activities are defined by the setting in which he is employed, his basic roles relate to the objectives of the vocational rehabilitation process, i.e. to assist the disabled individual to cope realistically and effectively with himself and move

"...to goals of self-realization and productive life."(19) Some question has been raised as to whether the rehabilitation counselor is in actuality a case manager or coordinator, rather than a counselor who has responsibility to provide direct, individual services to a client. However, the position of the National Rehabilitation Counseling Association as to what the rehabilitation counselor is and does is reflected in a statement prepared by Reger. (20) In summary he states:

> "Effective rehabilitation requires individualized, comprehensive, and integrated professional services. Rendering such services for an individual requires skillful rehabilitation counseling in the evaluation of the client needs, the definition of goals, and the implementation and integration of all professional and other services into a total plan for the achievement of these goals. In order to implement a total plan for rehabilitation, any rehabilitation counselor who accepts responsibility for counseling the handicapped must be the essential tie between the individual and various other professions and agencies that render services to the handicapped person.
>
> The knowledge, abilities, and skills needed by the rehabilitation counselor in order to be of optimum service to the handicapped individuals require a high level of professional training and well-supervised experience."(21)

Within this framework, McCauley (22) has suggested that one of the major characteristics of rehabilitation in general, and rehabilitation counseling in particular, is that it is oriented to the utilization of action techniques. Workshops, vocational evaluation, training, placement

are active instruments related to a determination of an individual's vocational handicaps, and the provision of appropriate services to reduce the handicaps to disabilities. Thus, the specific duties to be performed by support personnel arise out of the actions required by and for clients within the focus of the particular setting.

An underlying rationale in the use of support personnel is that the decision making responsibility remains with the counselor. The specific technique as to how the activity is carried out is the responsibility of the technician or specialist. For example, when the counselor decides that his client needs the services of a workshop, he will recommend the type of supervision required, not the types of contracts that the shop should have. If the client is recommended for training, the trade instructor not the counselor has the responsibility for developing curriculum. However, if the client is unable to benefit from training, the instructor has the responsibility to advise the counselor of the fact that there are problems interfering with the learning process. The counselor must then determine,with the client, the nature of the problem and if and how these can be alleviated.

Within this framework, support personnel fall into two general categories:

I. The first order of support personnel are those individuals who have been educated or trained in a specific skill, who are to be employed in activities directly related to their background. These may include:

1. Technical school graduate to conduct skilled or semi-skilled training classes.

2. Psychology majors to secure factual information from clients on the basis of a structured or semi-structured interview. Maintain liaison with other facilities. Administer and score psychological tests excluding projectives and individual intelligence tests.

3. Sociology major with business experience to act as supervisor for workshop.

4. Foremen to be employed as workshop foremen. (Neff has raised some question as to the use of the non-professionally educated foreman.) (23)

5. Employers who provide clients with the opportunity to achieve their rehabilitation goal.

6. The hospital librarian who can collect and catalog occupational information.

7. The statistics major who can maintain production records, gather follow-up data.

For these individuals, training will be directed to an understanding of the disabled and the operations of the agency rather than to the technical aspects of the job. This can be accomplished through a combination of orientation and continuing in-service training. The junior college, technical school or university can develop basic courses for several agencies as they have already been developed for the other health-related careers.

II. The second order of personnel are those individuals without specific training in required activities but who, for the combination of education and experience, can be utilized in the support function. These may include:

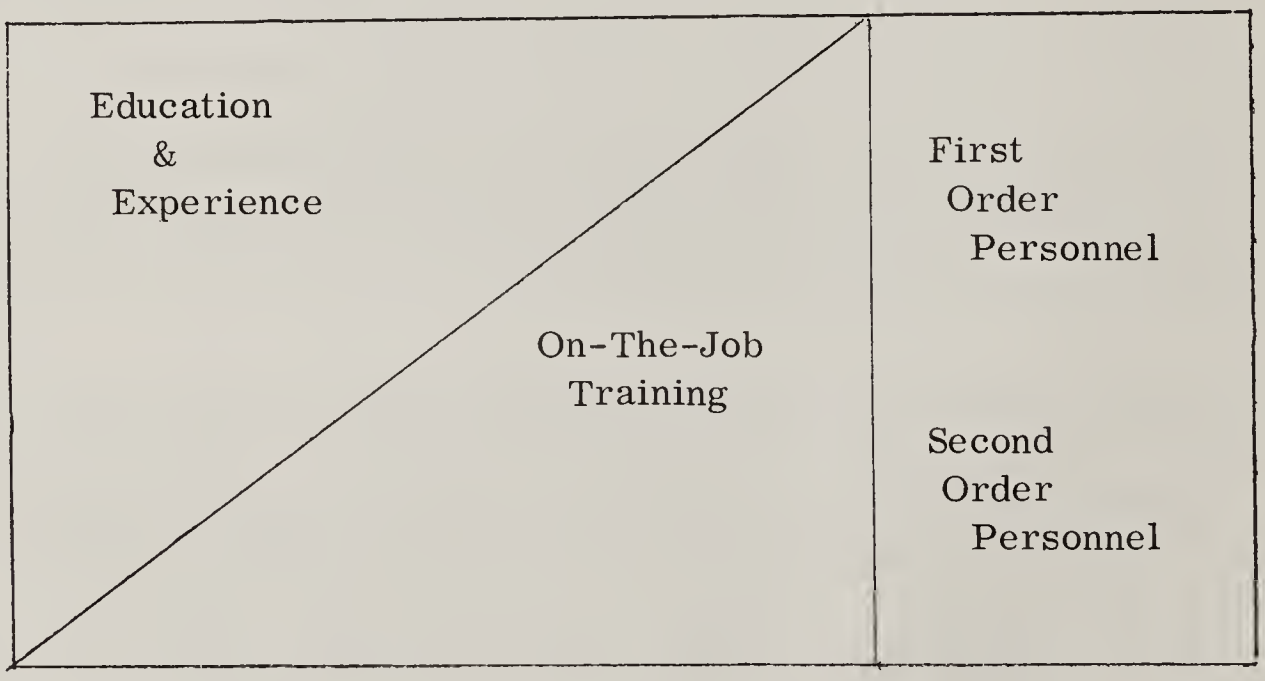
1. The retired business man who can solicit contracts or do job development.

2. The high school graduate who can help clients practice those things they have learned about the use of public transportation.

3. The grade school graduate, who can transport clients to the counselor's office.

For these individuals, training will be directed to their specific job duties as well as to assisting them develop an understanding of the clients of the agency and the agency itself. This can best be developed through general and specific on-the-job training, conducted by the agency.

The following chart, adapted from the theory-skill model developed by Kinsinger (24) portrays the relationship between the educational and experience background for the various orders of personnel and the degree of specific on-the-job training to be provided by the employing institution.



The recruitment of support personnel relates directly to the factors involved in retaining such personnel after they have been employed. The administrator must clearly define his and his agency's expectations concerning the duties to be performed and provide the opportunities for career advancement. This is of particular concern to those who have college degrees. For example, if the placement specialist must look to the rehabilitation counseling career line as his only means of advancement, he may be stimulated to matriculate for the Master's degree. However, if he has neither the ability to succeed at the graduate level nor the capability to perform as a counselor, he might become frustrated and then the administrator is confronted with the problem of recruiting another placement specialist.

Selection of the specialist must be based primarily on the individual's demonstrated or potential abilities to perform the specific tasks required of him. His job duties must be clearly defined. Opportunities for advancement must be available either within his own career line or, with appropriate education, to be able upon completion of his education, to move over to the counseling career line. In this respect, part-time education leading to a degree must be available through the university programs. The capabilities of the specialist must be recognized by the professional staff and, above all, he must have the personal characteristics of "empathy, warmth and genuineness" (25) and ethical behavior which are characteristics of any staff member.

Specifically, the recruitment of first order personnel may take the form of contact with placement officers, brochures and other techniques presently used in the recruitment of professionals. It must be recognized that at this level particularly, there is a keen competition for personnel. We are trying to recruit suitable students into graduate training. The draft has a marked influence on the choices of male students. The other disciplines are competing for the same personnel. For the technical person wages and security may be much better in other fields.

A major pool of personnel which has come to the fore is the married woman whose family is grown and is now ready to return to the labor market. Often, with short-time training, she can brush up on former skills.

For the second order of personnel, recruitment can often be accomplished through the utilization of indigenous personnel, i.e. clients or former clients of the agency. Other resources may be the retired or semi-retired, employment agencies, newspapers, friends of present employees and the other usual resources of personnel.

Selection of personnel in all categories is based primarily on the individual's demonstrated or potential abilities to perform the duties for which he is to be hired. The understandings and techniques developed in counseling and placing clients should be applied to our employment practices, i.e. interviewing, gathering of collateral background information, testing and job try-out. Transcending all other considerations, the potential support person must have empathy, warmth, genuineness and ethical behavior, characteristic of any valued staff member in a rehabilitation facility.

In conclusion, the advantages of the use of support personnel relate to their abilities to provide skilled services when and where they are required by and for clients. Their role responsibilities relate to their abilities and therefore will not interfere with the relationship to the counselor. While an extension of the use of such personnel in rehabilitation may require an alteration in the roles of the counselor, we must insure that whatever changes do occur will be in the best interests of the client, the profession, the counselor and the administrator.

Prepared for

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Subdoctoral and Supportive Personnel in Psychology

Shalom E. Vineberg, Ph.D.

There are approximately 25,000 members in the American Psychological Association (A. P. A.), an impressive increase over the 8500 in 1951 (1) and 18,000 in 1960 (2). The rate of growth, however, has peaked and is now rapidly diminishing. The prospect is for a stabilization in membership at about 30,000 in the early 1970's, unless something unforeseen provides the basis for new growth (2).

The current surge of growth began in the 1940's. In the 1940's and early 1950's, the mean age of students attaining the Ph.D. was 35 years. Thus, as we approach the 1970's, psychology comes of age and begins to contribute its fair share of members to Medicare and Golden Age Clubs. In the early 1970's, it is estimated that the attrition rate due to death, retirement, and occupation change will about equal the rate of induction (2).

The deceleration in growth rate in psychology is occurring in the face of a galloping increase in the demand for psychologists. The slowdown is largely a result of faculty shortages. Mushrooming community demands and constantly increasing job opportunities for all varieties of psychologists are creating a growing shortage of faculty members. One estimate (2) made in 1963 predicted that 800 new psychology faculty members would be sought in 1965 by colleges and universities. The U. S. Office of Education recently reported (3) that in 1965 all U. S. universities combined granted 847 Ph.D.'s in psychology. Obviously the universities did not get their recruits.

The failure to step up production is not due to a shortage of students. Departments are reporting acceptance rates of 1 to 20, 30, and 40 applications. While it is difficult to know how many real applicants there are, when students apply to more than one university, it is also true that the very tendency toward multiple applications increases as chances for admission decrease.

So the bind is complete. Great demand for product greatly limits the available teaching personnel, which reduces the capacity of departments to accept students for training. Psychology could strangle in the noose of its own prosperity.

The Ph.D. degree represents the educational requirement for entry into professional status in psychology and into membership in the A. P. A. This is reflected in the requirements set for certification and licensing around the country. Of the 43 states which license or certify psychologists, only five provide professional status at the M. A. level. Twenty-six of the 43 states have boards established by law; only one (Maine) permits certification as a psychologist without the doctoral degree. Of the seventeen states with non-statutory boards, four permit certification as psychologists at the M. A. level, but require two to four times as much experience after the M. A. as after the Ph. D. (4).

In discussing supportive personnel for psychology, we are, therefore, speaking of individuals trained at the M. A. level or below, and bearing professional titles other than "psychologist." Incidentally, five of the above 43 states now offer certification with an M.A. at a secondary or supportive level (usually as "examiner" or "technician").

What is the position of the American Psychological Association on the training of subdoctoral or supportive personnel? There is no formal statement of the Association on this subject. However, a number of A. P. A.-sponsored conferences on professional practice and training have approved, supported, and even applauded the training of personnel at the M. A. level, to serve as technicians, psychometrists, and counselors (5). A few universities have undertaken such training--some even at the B. A. level--but there are no signs of a mass movement in this direction. There has not yet, for example, been a national conference on sub-doctoral training in psychology.

There are, to be sure, many terminal M. A.-granting psychology departments in the country, primarily in state colleges. But these are not really terminal degrees in the sense of providing credentials for entry into a profession or qualifying one for some existing occupation. These M. A. students are rather like the M. A. students in university departments, prepared only to continue on to the Ph.D. The M. A. signifies an uncompleted doctorate.

The M. A. department stands in the same relation to the university graduate department as does the junior college to the four-year college. In psychology there is no prestige yet attached to the training of technicians, and M. A. departments aspire to become Ph.D. departments rather than to turn out finished M. A. products. What happens to the graduate M. A. students? They apply to Ph.D. programs--some get accepted, some don't; they go to work; they change occupational objectives. We have no careful study of either M. A. graduates or of university rejections.

To an intelligent, disinterested observer, it might appear that in these terminal M. A. programs reside the resources--in students and in faculty--for subdoctoral, professional training. But disinterested observers don't run psychology departments.

There is a growing awareness that professional psychology will soon be in a fantastic jam if it does not undertake the training of supportive personnel. There is no hope of meeting present commitments and responding to new needs in the community with the tiny crop of Ph.D.'s alone.

Why, then, is psychology so slow in developing programs for supportive professions? Because psychology is still clarifying its position on professional activity in general, and because psychologists engaged in professional training and practice are pulling in a number of different directions.

The American Psychological Association was not established as a professional organization and although it describes itself as a scientific and professional body, it is not yet fully comfortable with its professional profile. Nor can American psychology be said to be wholeheartedly engaged in the education of professionals. The training of all psychologists is conducted in the same departments and, in these departments, competence in research and scholarship in academic psychology are the primary requisites for success. One large university has recently undertaken the separate training of professional psychologists at the doctoral level (not the Ph.D. but the D. Psy.) but this isolated experiment does not yet forecast a trend. The university faculties and the A. P. A. membership rejected this new approach after an agonizing debate which climaxed at the 1965 A. P. A. convention.

It is not quite proper to attribute the current situation in professional training totally to wavering commitment. There is, among psychologists who conduct such training, the conviction that the surest route to professional (or clinical) progress is through research and that, therefore, the most effective professional is one trained to evaluate and innovate rather than merely practice. There is also a suspicion in many university departments that professional psychology has not yet come into its own; that the tools of the trade are too tentative and too unproven to warrant pride in the proficiency of their use.

On the other hand, there are great pressures from within psychology for increased professional emphasis--both in the sense of more intensive involvement by individual psychologists and in the sense of graduating a greater number of professionally-trained psychologists.

There is, for example, much agitation within clinical psychology for changes in training and in function leading to increased professionalism. The proposed changes are not all in the same direction. There are "orthodox," "conservative," and "reform" forces at work. The "orthodox" group seeks radical non-change, an intensification of, and greater commitment to, the precepts and the liturgy of the past. The "conservatives" wish merely to update and modify the old formulations to fit modern times and modern language. The "reform" group seeks to break with tradition and strike out in new directions, viewing traditional clinical psychology somewhat as Reinhold Niebuhr once described organized religion: as a collection of magnificent answers to questions which nobody is asking any more.

Regardless of the orientation, all these winds are blowing in the direction of more service to more of the community. And the issue of supportive personnel is now moving up on the agenda.

The relations between psychology and rehabilitation are old, intimate, and enduring. However, systematic training of psychologists in rehabilitation is a recent development. In 1958 the Vocational Rehabilitation Administration (then OVR) awarded its first training grant to a doctoral psychology program. There are now about ten such programs. Their impact on rehabilitation is, thus far, scattered--the products of the programs are not standard, and the list of jobs into which they are hired is long. It may, therefore, be some time before the model (or models) of the "rehabilitation" psychologist emerges.

1958 was the year of commitment to the task of articulating the role of the psychologist in rehabilitation. In addition to the first doctoral grant, it was also the year of the Princeton Conference in Psychology and Rehabilitation (6), and the year of creation in the A. P. A., of the Division on Psychological Aspects of Disability.

Psychologists in rehabilitation share the dilemma and the urgencies of their colleagues in the A. P. A. regarding professionalism, professional training, and supportive personnel. (Even the "model" problem is not unique for rehabilitation.) And the solutions will begin to take shape in the double form already apparent: stirrings at the center--clarity, steadily growing in the Capital; and daring, independent experimental programs springing up in the provinces.

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Editor's Note

The Division of Counseling Psychology of the American Psychological Association has been considering the problem of concern in this conference in its Education and Training Committee. This Committee gave a report of its deliberations at the 1966 American Psychological Association convention in New York City.

The Committee report is in the second-draft stage, and could not be published, but is available to interested persons from Division 17, The Division of Counseling Psychology, of the American Psychological Association. This report "Recommended Roles for Counseling Psychologists in the Development of Counselor Support Personnel," very clearly delineates counseling psychology's role in the training of support personnel, and points out many of the problems which could be generated by ignoring the need for personnel supportive to counselors.

General Discussion - Preliminary Remarks

by

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I have some reactions to the matter of our mad search for personnel and manpower efforts and I hope that I will not be misunderstood. There is no doubt of the fact that search for various professional groups to meet this problem is essential. But, there are other aspects that must not be forgotten in the process. All too frequently when we do get into a discussion about manpower needs, we expend all of our energies worrying about manpower needs and forget about the needs of those who are to be served in the process.

Yesterday I had the privilege of participating in a meeting with NASA and certain of VRA grantee programs, in an effort to try (on a preliminary basis) to establish a collaborative relationship in just a few of our programs. Certain relationships need to be established between the vast treasury of information that is beginning to accrue out of the space efforts and the many researchers who might very profitably utilize the gains and knowledge that have come out of the efforts to supply the manned spacecraft with adequate equipment to meet many of the problems relative to spending considerable periods of time away from the heaven on earth from whence they come.

I think it is rather remarkable that today we have a lot of answers to questions that no one is asking because, that's exactly what we do have. As a matter of fact we probably have more answers today for problems than have ever existed within the entire span of man's life on earth. There are many questions and our only problem is to bring the people who have the questions together with those who have the answers. We are now actually engaged in the process of circulating answers to a lot of interested people who may (if they give it some thought) find the kind of questions that these answers would solve, or which may be valuable in helping solve hitherto unsolved problems. There are literally hundreds of millions of dollars worth of research floating around somewhere between here and about 850 miles out from the world's atmosphere. I think it's rather sad when somebody comes up with a device by which one can study perceptions in space, while here on earth there is some poor fellow in a laboratory that is breaking his neck trying to find a device that's exactly like this instrument, and he doesn't even know about it.

Now, one cannot be too sure that the personnel problem, in many ways, doesn't have comparable kinds of aspects to it. Most of the discussions on manpower that I've been privileged to hear in the last few years have always dealt with how one divides up and reduces down less than adequately trained personnel so they can serve more people. We should be equally concerned with some efforts being made to find ways of establishing what people need what kind of services. That isn't really being adequately touched! It's well and good to

establish whatever subprofessional levels are needed but, again, may one point out to you that if you have a client .... if you have a patient .... if you have a human being (and Charlie Truax pointed out this so well .... you have empathy and warmth, and genuineness) this is reflected in what you do for that patient or client. Yet the only thing that you can do is to see to it that they are put into contact with some other human being or some resource that can help them solve the problem. Every one of these individuals requires something that is, more or less, specialized but may not require as much training as any given profession considers its peak level of training. There is also equal necessity to think in terms of how you separate out the recipients of services so that you know what kind of an individual with which the client will do best. If you don't carry out such studies of client needs at the same time, you will never reach a solution to this problem. The rate of population growth is always going to greatly exceed the number of professionals and, if you please, subprofessionals, and, if you please, sub-subprofessionals, that you're going to be able to produce. No matter how you cut it you've got to train people to do what you're asking them to do.

So, I don't think it's just the simple process of deciding either in our professional organizations, or in our institutions that are making use of personnel, or in our extrainstitutional programs that are making use of personnel who they're going to get by hook or crook. Sooner or later, you'll find that the public can only be fooled so long and a thin layer of veneer doesn't provide the same protection against the wear and tear of the outside world. I do think that we must apply this in developing professional training programs at any level. Having gotten that off my chest I wish to open up this meeting to "free" discussion.

Discussion Summary

General agreement seemed to reign concerning the fact that rehabilitation facilities must take the primary initiative in solving the personnel shortage now extant. The exact nature and plan of this initiative, however, was not fully agreed upon nor developed. The following excerpts from discussion group reports illustrate the kinds of solutions or first order activities suggested at this meeting.

1. It is necessary that the rehabilitation facilities explicate the role of supportive personnel in rehabilitation facilities and present this to the various professional organizations so that selection procedures and training techniques can be agreed upon.

2. Perhaps the Association of Rehabilitation Centers, Inc., should have a spokesman who could go to the professional organizations for assistance in working out the problem. If the organizations cannot assist, then they could agree to accept what the facilities arrange in the form of a solution to the manpower problem.

3. It would seem imperative that the facilities explore fully all possible resources in their communities for any possible relief to the personnel shortage. Suggested sources of assistance mentioned included junior colleges, colleges, vocational-technical schools, and on-the-job training programs.

4. A suggestion was made that the rehabilitation facilities examine a possible parallel to the military corpsman-type program, in which a "corps curriculum" might be established to train "aides, assistants, or supportive personnel," who could then receive specialized training in an inservice training program within the particular facility.

5. It was suggested that some sort of standards should be implemented at the outset of training supportive personnel so that job mobility could be enhanced through interstate or interarea reciprocity of job requirements.

6. The question of, "who would supervise the supportive personnel?", was raised and seems to be part of the larger question, "will these people be trained as supportive personnel, or will they be trained as independent workers?"

   General agreement seemed to hold that the facilities should aim at the supportive level to "increase the hands" of the professionals. Therefore, the matter of supervision seems to be answered in terms of which department the supportive person works.

7. It was stated that salaries of both professionals and supportive personnel need to be considered in view of local and national trends in order to remain competitive in the rehabilitation facilities.

8. An intriguing point was raised concerning the use of administrative supportive personnel to increase the time the trained professionals could devote to service or program activities.

9. One group stated that there are many, short-term, temporary solutions to the manpower shortage which an individual Agency or Facility could employ. However, these will not answer the need, in reality, since they could not be based upon a comprehensive, universal approach to the manpower shortage. Therefore, a multidisciplinary forum must be formed where problems could be discussed and decisions be made as to who could be brought into the personnel picture in the supportive role, what their role should be, where they should be trained, and how the training should be accomplished.

10. It was pointed out that most people who would be included in the supportive personnel category are highly subject to unionization at this time. Therefore, if the professional organizations and/or the rehabilitation facilities do not explicate the role of support personnel, the unions may soon do it for them.

11. It would be very helpful, both to the professional groups and the rehabilitation facilities, if those Agencies already utilizing supportive personnel could elucidate the role they are now playing, selection procedures, etc. In this manner both groups could reach a rapprochement, perhaps, in their thinking about supportive personnel, and the facilities could benefit from shared experiences.

12. Another point mentioned is the fact that many vocational-technical schools are training various medical technicians on a two-year basis, providing them with the possibility of using credits gained toward a subsequent four-year degree program in college if they so desire. Perhaps this approach could be utilized in the training of supportive personnel for rehabilitation facilities.

In addition to these points raised during the small group discussion, several items of interest were shared during the general discussion sessions.

One recurrent theme throughout the discussion sessions centered around the need for the Agencies and Facilities to take a close look at their present utilization of professional staff. It was stated that many Agencies have a policy or practice of promotion of service personnel into more administrative positions, in order to justify salary increments, etc. It would appear patently obvious that such practices result in a loss of professional service time to the clientele of these Agencies. Many people at this conference felt that more efficient utilization of administrative support personnel might lessen this service decrement, but at some point the question must be faced, "Is it more efficient to utilize professional personnel in administrative functions, or would administrative personnel be more easily acquired and trained in the specifics of rehabilitation unit administration?" Are we not defeating ourselves in the manpower race by placing trained professionals out of the service role into the administrative role?

Another aspect of this basic question is, "What standards should be expected in the various professional areas from the trained personnel?" How many patients or clients should a therapist, social worker, or counselor work with each day? Under what conditions would the maximum number of patient or client service hours be possible for a given staff member? In short, what standards do we now have concerning quality and quantity of patient or client contacts with our various professional personnel?

During a general discussion session one participant made the point that several of the professional organizations are still struggling to gain professional identity and respectability and are probably not going to be overly interested in fostering the development of personnel or personnel categories which they might interpret as impeding this struggle. Several organizational representatives discussed the pros and cons of admission of support personnel as associate members of their groups. The general concensus seemed to be that support personnel would not presently be welcomed into membership in the professional organizations on any basis. Thus, it would seem that an identification problem could develop, in the ranks of the supportive personnel, even though general agreement might be reached concerning their training and utilization.

Another aspect of this conference was discussed in the general sessions as well as the small group sessions. This matter concerns the possible levels and types of training which would best prepare supportive personnel. Although the great majority of supportive personnel would probably be functioning in pure service roles, most people seem to think of their training in terms of formal didactic experience rather than clinical or practicum experience. Therefore, most comments centered around "core curricula" and "Associate of Arts degrees," rather than around supervised patient or client contacts. Perhaps the primary reason for our thinking of didactic as opposed to experiential experience for these people is related to our long-standing attitudes toward education and to a relative lack of research data supporting any other approach. It would seem that we are unable to entertain the notion that a person might be able to function in a service capacity without two or more years of formal academic training beyond high school. However, we have little data to support the notion that academic experience relates positively to increased proficiency in the service role or the "helping relationship." Therefore, it would seem most relevant for some research to be conducted which might shed some needed light on this subject. Perhaps, as an outgrowth of this conference, some group or agency could conduct a pilot research study to determine if high school graduates, with specific experiential on-the-job training are, in fact, less able to function as supportive personnel than persons holding the Associate of Arts degree. It may well be that efficiency on the job is more related to personal factors such as maturity, judgment, and attitude toward people, than to the curriculum in which the person is trained. The apparently logical conclusion to this question would involve a combination of experiential and didactic training but probably at less than the Associate of Arts degree level. The didactic part of the training, however, would, of necessity, be highly focused and specific and in no way general.

Another question pertinent to this discussion is, "Who should provide the training for supportive personnel?" The participants at this conference seemed to feel that junior colleges or vocational-technical schools could provide the didactic part of the training, but the rehabilitation facilities must play the major role in the on-the-job training or experiential portion.

The various questions and problems concerning the "Selection, Training, and Utilization of Supportive Personnel in Rehabilitation Facilities," generated at this conference, decry an urgent need for some group or organization to accept the responsibility for developing a systematic plan of operation to solve the manpower shortage in rehabilitation facilities. This organization must be one which is familiar with the role and function of the various

professions usually found in rehabilitation facilities. In addition, this organization must be able to communicate with both the professional organizations and the rehabilitation facilities.

The conference participants seemed to all agree that the one organization which meets the above criteria is the Association of Rehabilitation Centers, Inc. Therefore, the group wished to go on record as recommending to the Association of Rehabilitation Centers, Inc. that it consider the possibility of taking the responsibility for developing a plan for the selection, training, and utilization of supportive personnel in rehabilitation facilities. Furthermore, it was recommended that all Agencies and Facilities, already utilizing supportive personnel, send reports of their experiences to the Education Committee of the Association of Rehabilitation Centers, Inc.

Conference Summary
Richard D. Burk, M. D.

Now, what have we accomplished????

I doubt that any of us came here so grossly misled as to really expect that in two and one-half days of deliberation we would solve the health manpower problem. We did succeed in bringing groups together, center with center, profession with profession, profession to center .... many, for the first time. As a result, what we did was to give you a chance to "air" your problems and,in so doing, to learn that you are not unique, that others have the same problem, others in the profession, in the centers. I think we made the centers a little bit more cognizant of the problems, the goals, and the attitudes of the professions and, conversely, we made the professions aware of the somewhat unique problems that we have in rehabilitation centers.

We were reminded that staffing problems of centers, while parochial to us, cannot be viewed parochially by the professions .... to them we are simply one facet of a much larger problem and, in all fairness, we cannot expect them to be overly concerned in providing us with a special or private solution.

We also learned something of the insecurity of the professions, those with which we are involved. We learned that many of them are engrossed in a struggle to establish their own identity, not unlike the struggle in which rehabilitation centers have been so long engaged. Professions want to become established, recognized and, in pursuit of this, may be forgiven for being somewhat suspicious of innovations that may appear on the surface to interfere with that larger and more personal goal.

Lastly, I think that we have learned that the prospects for the immediate, and most probably, post-immediate as well, relief of our staffing problem, are not very good. We will have to try to continue to work out our own solution as best we can, as we have been doing.

In this regard, I think there are a few points that have been reaffirmed at this meeting, that I believe warrant our most careful attention. I refer to them collectively as the over-riding problems. First, the needs of the people we serve will be met. Secondly, we have a moral responsibility to assure our patients and clients quality care. These two problems, then, represent the crux of our present dilemma. Rehabilitation can no longer be disbursed on a charitable basis, as a result of the benevolent, well-intentioned philanthropist. It is now accepted, recognized, believed in and, therefore, is demanded. If we, the professions, do not develop methods of meeting this express need, legislators will .... to wit, Medicare.

The public will not tolerate interagency, interprofessional jealousies, insecurities, pure self-interests, or intrinsic desires. The public is not one whit interested in helping a particular profession secure its hold in an area of endeavor and enhancing the prestige of the particular group. It is interested in one thing. Quality service in sufficient quantity.

Many don't know that our particular profession exists, let alone what it does! The public brings to us seemingly simple questions and want simple answers. The fact that we know that they are not always simple, is of little interest to them .... only their solution is. The onus is upon us then, to determine what really are the needs of the people we purport to serve? Both as they perceive them and as we perceive them. Secondly, we need to develop the techniques and criteria of selection of clients whom we can help with what we now have to offer. In this regard, I would give you one word of caution. Don't throw the baby out with the bath.

Remember that a profession is more than a provision of a specific technique or skill. These are only the visible manifestations of that which emanates from a broad background of understanding how that particular skill or technique fits into the total patterns of solutions, applicable to the given client's problems, at a given point in time. If we need technicians to provide this skill, fine, let's do it, but our basic reliance remains dependent upon those who can provide us an overall understanding of a client's special needs, as they in turn relate the needs to his overall function as a social being, in a very complex social system.

I think that, in effect, what I have tried to do is not to say what each of you said, but in turn to give you an overview of where I think we are and what I think we have done in two and one-half days. I hope that a little bit of an idea has come from where we could go from this rather modest beginning. It's been a real pleasure for me to have been with you.

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